

Good Morning!



It's morning...Yippee

Community Services to Access Recovery
presents

**“The ASAM Criteria:
Treatment Criteria for Substance
and Co-Occurring Conditions”**

July 7 & 9, 2015

Milwaukee, WI

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Training & Consulting in Behavioral Health

The Need & The Goal

NO WRONG DOOR!

The need to integrate substance use, mental health and case management in:

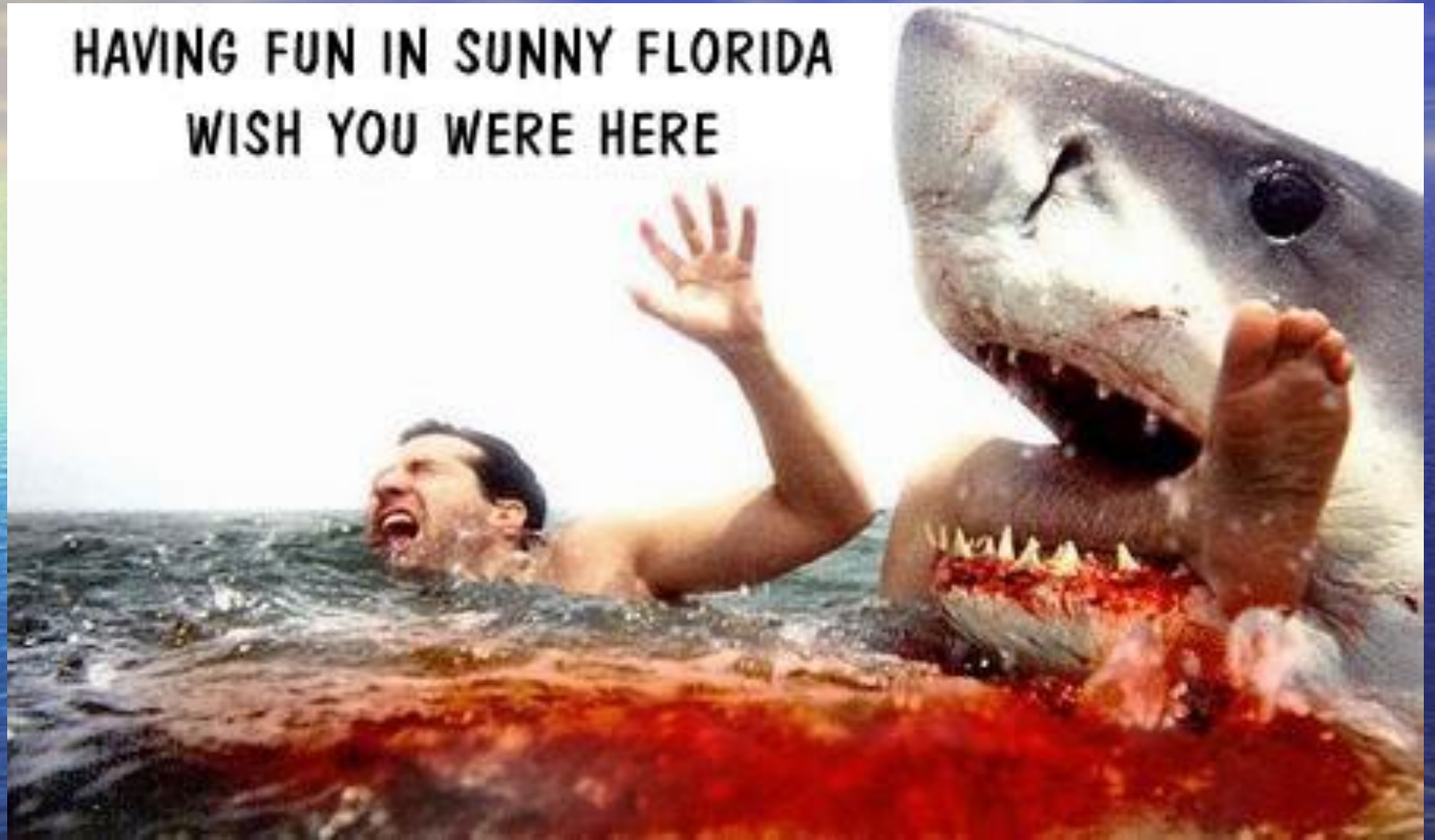
- Assessment
- Treatment Planning
- Treatment



It takes two things to be a consultant -
Gray Hair and Hemorrhoids.

The *Gray Hair* makes you look distinguished -
The *Hemorrhoids* make you look concerned.

HAVING FUN IN SUNNY FLORIDA
WISH YOU WERE HERE



Dear Participants:
I know when you are texting in class.
Seriously, no one just looks down at
their crotch and smiles



Sincerely, Your Trainer



Our Kinds of Folks



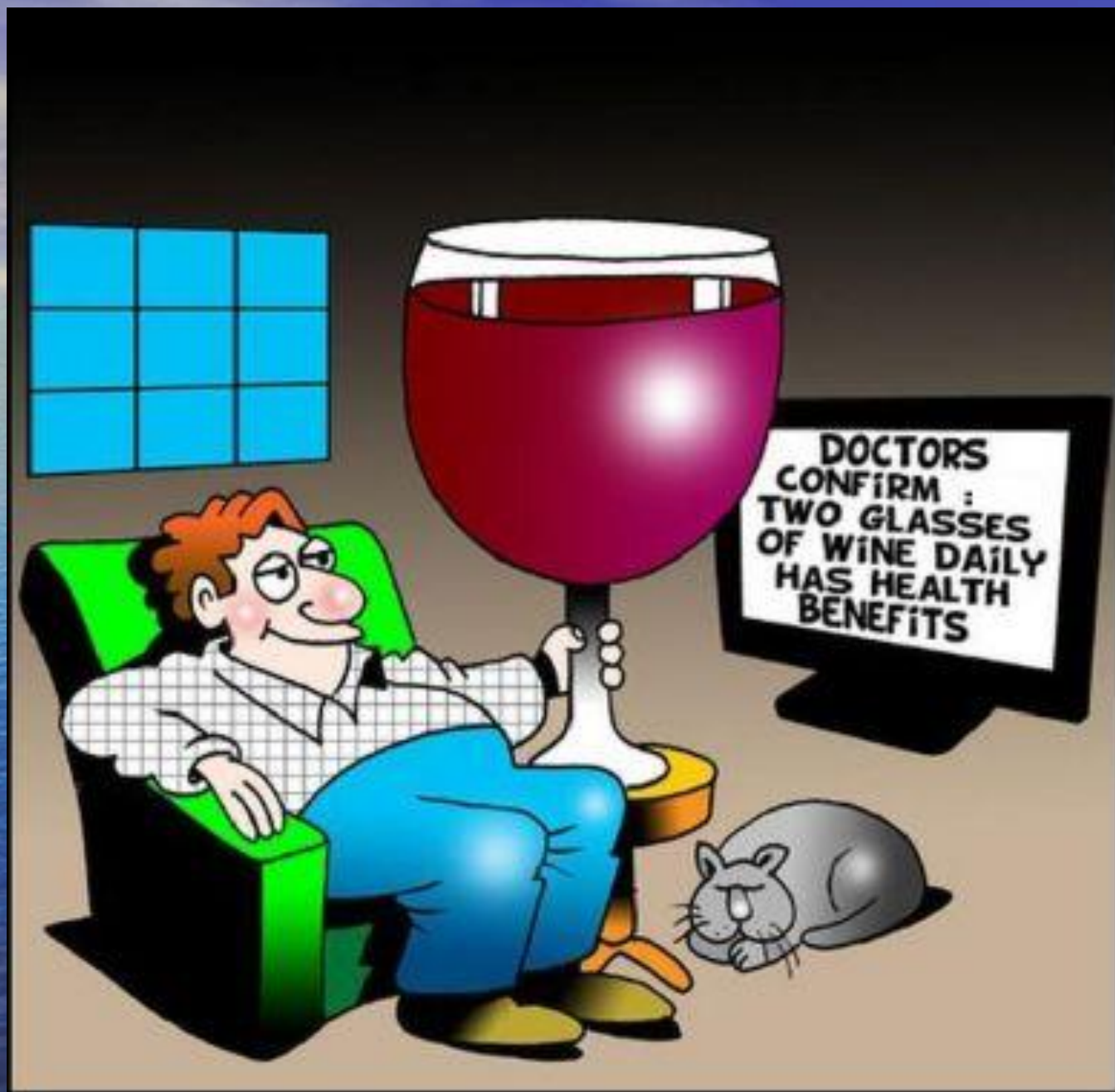





"Did you bring the weed?"









Dude, we totally
forgot our slogan

American Medical Marijuana Assn.

INFINITY

POST



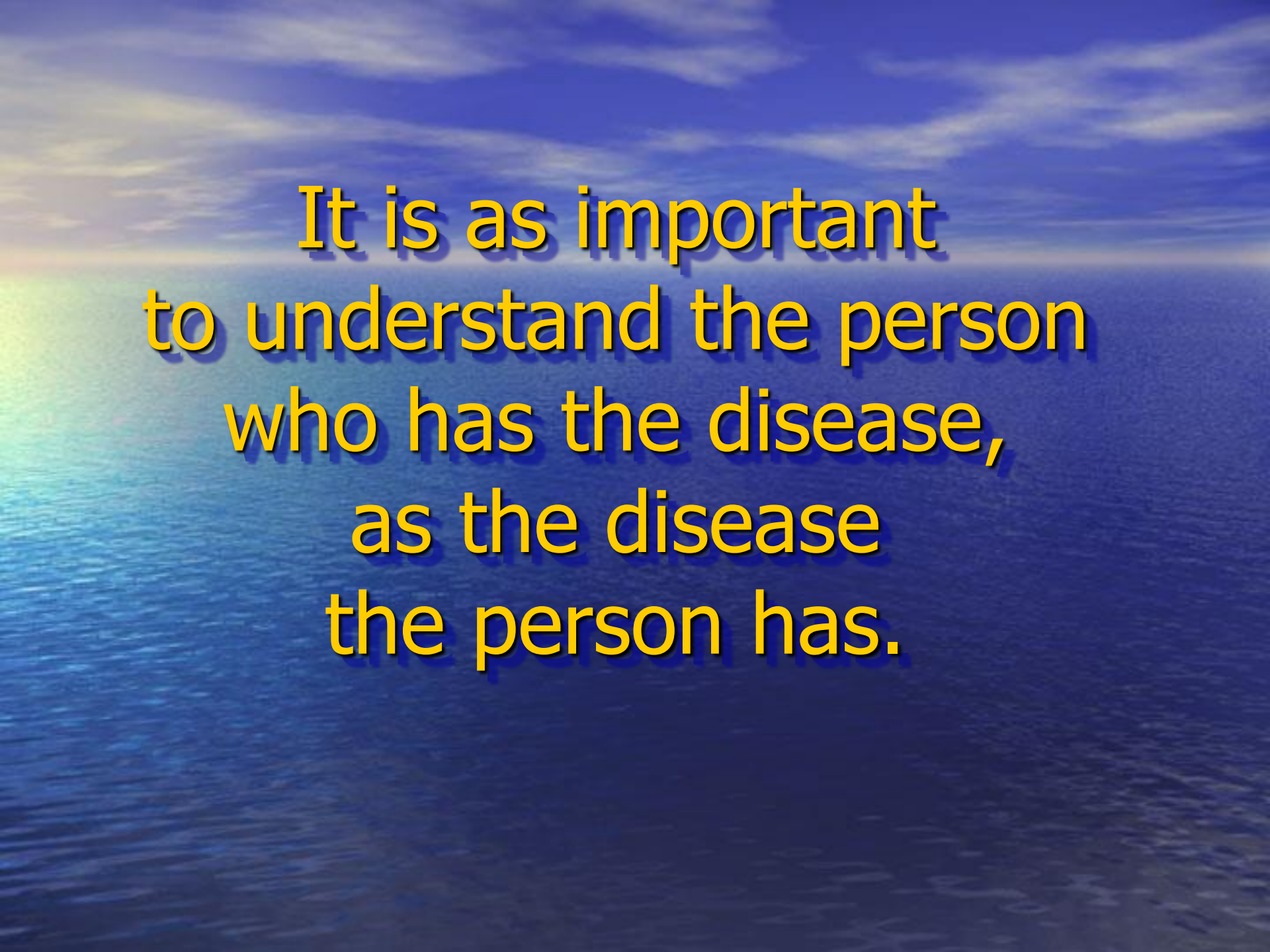


**I love long walks on the beach
with my girlfriend, until
the LSD wears off and
I realize I'm just dragging
a stolen mannequin around
a Wendy's parking lot**



www.Jokeworm.com





It is as important
to understand the person
who has the disease,
as the disease
the person has.

CARE SHOULD BE MANAGED

.....in fact.....

**“the *Hallmark* of Quality
Treatment
is the
Management of Care”**

SCREENING

**Screening instruments are
“quick, cheap and easy”
and their purpose is to:**

- Rule individuals “out” or
- Rule individuals “in” for further assessment

Screening for Alcohol Problems

CAGE

1. Have you ever felt the need to **CUT** down on your drinking? Yes ____ NO ____
2. Have you ever felt **ANNOYED** by someone criticizing your drinking? Yes ____ No ____
3. Have you ever felt **GUILTY** about your drinking? Yes ____ No ____
4. Have you ever felt the need for an **EYE OPENER** to get you started in the morning? Yes ____ No ____

UNCOPE

- U** “In the past year, have you ever drank or used drugs more than you intended to?”
- N** “Have you ever **neglected** some of your usual responsibilities because of using alcohol or drugs?”
- C** “Have you felt you wanted or needed to **cut down** on your drinking or drug use in the last year?”
- O** Has anyone **objected** to your drinking or drug use?”
- P** “Have you ever found yourself **preoccupied** with wanting to use alcohol or drugs?”
- E** “Have you ever use alcohol or drugs to relieve **emotional discomfort**?”

TICS

1. In the last year, have you ever drunk or used drugs more than you meant to?
2. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

Detected current substance use disorders with nearly 80% sensitivity and specificity and particularly sensitive to polysubstance use disorders.

Respondents who gave 0, 1, and 2 positive responses had a 7.3%, 36.5%, and 72.4% chance of a current substance use disorder, respectively



COMPREHENSIVE ASSESSMENT



EVERYONE NEEDS THE SAME TREATMENT.

Why Do In-Depth Assessment?

- To avoid the preceding

and to:

- Best match patients to type and intensity of care
- Enhance outcome
- Provide the most cost-effective treatment
- Defend clinical decisions

Assessment

**At the Beginning, ^ middle, ^ and ^
end.....**

And at all points in between!

ASSESSMENT

is an ongoing process that is

***PART* of treatment,**

***NOT* simply**

an activity that

determines treatment

**The Quality of Treatment
Delivered
Can Never Rise Above
the
Quality of Assessment
on Which It Is Based**

Treatment Outcome



**Treatment
& Care Management**



Treatment Planning




Assessment

The Goal

Making The **RIGHT** Placement(s) Providing:
the **RIGHT** services
in the **RIGHT** amount
at the **RIGHT** intensity level
with the **RIGHT** structure & support
to the **RIGHT** people
at the **RIGHT** time
in the **RIGHT** place
at the **RIGHT** price
to achieve the **RIGHT** outcomes



Diagnostic Assessment



The DSM-5 Diagnostic Criteria for Substance Use Disorders

The DSM-5 Diagnostic Criteria in the New ASAM Criteria

The new ASAM Criteria language is
consistent with the DSM-5 Criteria

DSM-5 Criteria for Substance Use Disorders

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by two (or more) of the following, occurring at any time in the same 12-month period:

- (1) tolerance
- (2) withdrawal
- (3) the substance taken in larger amounts or over a longer period of time than was intended
- (4) there is a persistent desire or unsuccessful attempts to cut down or control substance use
- (5) a great deal of time spent is in activities necessary to obtain the substance, use the substance, or recover from its effects

DSM-5 Criteria for Substance Use Disorders (cont)

- (6) important social, occupational or recreational activities are given up or reduced because of substance use
- (7) substance use is continued despite knowledge of having persistent or recurring physical or psychological problems that are likely to have been caused or exacerbated by the substance
- (8) Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home
- (9) Recurrent substance use in situations in which it is physically hazardous
- (10) Craving
- (11) Continuing substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

Changes in the DSM–5 Diagnostic Criteria for Substance Use Disorders

Changes from DSM-IV

- Meeting 0-1 of the 11 criteria results in no diagnosis
- Meeting 2-3 criteria qualifies as ***Mild*** (akin to old “abuse”)
- Meeting 4-5 criteria qualifies as ***Moderate*** (akin to old “abuse” or “dependence”)
- Meeting 6 or more qualifies as ***Severe*** (akin to old “dependence”)

Characteristics of Addiction

- Compulsion
- **Loss of control**
- Continued use in spite of negative consequences
- Craving

Beep Beep! I'm a milk truck!

Go home Bessie, you're drunk!

Changes in the New ASAM Criteria

- Section on four Special Populations:
 - People in the criminal justice system
 - Older adults
 - Parents with children
 - People in safety-sensitive occupations
- Opioid Maintenance Treatment (OMT) now Opioid Treatment Services (OTS)
- Section on working with managed care
- Section on Tobacco Use Disorder
- Section on Gambling

Changes in the New ASAM Criteria

- Criteria more strength-based, empowering and recovery-oriented
- Language changes
- No change in description of levels of care
- Level of care numbering system changed from Roman to Arabic
- Name for Level 3.3 changed from “Clinically-Managed, Moderate Intensity Residential Treatment” to “Clinically-Managed, High Intensity, Population-Specific Residential Treatment”
- Opioid Maintenance Treatment (OMT) now Opioid Treatment Services (OTS)
- Section Tobacco Use Disorders

Changes in the New ASAM Criteria

- Criteria more strength-based, empowering and recovery-oriented
- Section Tobacco Use Disorders



Tobacco Use Disorders

- Change from Nicotine Use Disorders in the DSM-IV
- Special attention because:
 - Of its lethality
 - It is rarely treated in SUD programs
 - BUT . . . nicotine is the determinant of addiction to tobacco
- While it is mood altering, it is not associated with the same behavioral disruption and social and legal consequences as other drugs

Tobacco Use Disorder

- More people die from the use of tobacco and second hand smoke than die from the use of alcohol and the other drugs, homicide, suicide and WW II combined
 - Smoking serve as a trigger for relapse to other drugs
 - When the route of administration of the drug of choice is smoking (e.g., “crack”), the risk is increased



Note on Varenicline (Chantix)

FDA: Chantix Carries Potential Alcohol Interaction and Seizure Risk

Linked to almost 50 adverse events involving alcohol

- decreased tolerance
- aggressive behavior
- amnesia

Tobacco Withdrawal

Within 24 hours of cessation of use by 4 or more of the following:

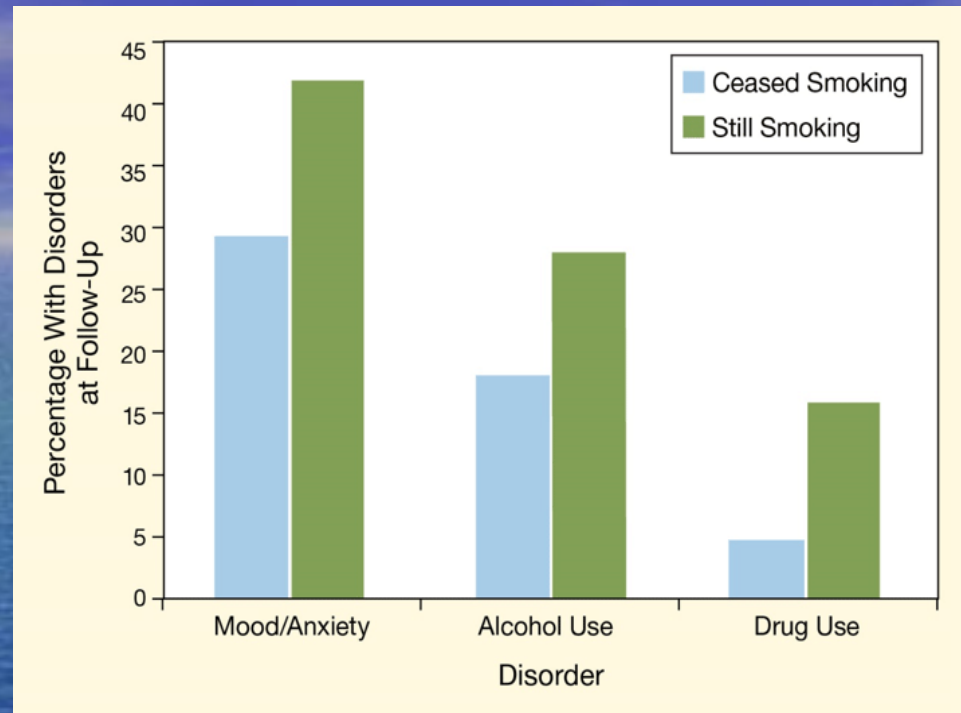
- Irritability, frustration or anger
- Anxiety
- Difficulty concentrating
- Increased appetite
- Restlessness
- Depressed mood
- Insomnia

Criterion of “Decreased heart rate” from DSM-IV out

Recent Study

- Psychiatric patients who took part in a smoking-cessation program while they were in the hospital for treatment of mental illness were more likely to quit smoking and less likely to be hospitalized again for mental illness, a new study shows
- 224 patients at a smoke-free psychiatric hospital in California
- Eighteen months after leaving the hospital, 20 percent of those in the treatment group had quit smoking, compared with 7.7 percent of those in the control group
- Forty-four percent of patients in the treatment group and 56 percent of those in the control group had been readmitted to the hospital.

Smoking Cessation Is Linked to Reduced Prevalence of Substance Use and Mood/Anxiety Disorders



- Some survey* participants with current or past histories of the disorders quit smoking during the 3-year period between initial and follow-up interviews. Compared with participants with such histories who continued to smoke at or near their initial intensity, these people who quit were less likely to have current diagnoses of the disorders at the follow-up interview.
- * NESARC, 2001–2002



Public Health Prevention Model

- Types of Prevention
 - Primary
 - Secondary
 - Tertiary
- The role of secondary prevention and smoking

Nicotine Alternatives to Smoking

- “Hookah” use is going up in all age groups
- There are current e-cigarettes that allow the adjustment in the amount of nicotine in each puff
- A particular risk to children and adolescents because marketing in flavors (e.g., bubble gum)
- Safer than tobacco but safe???

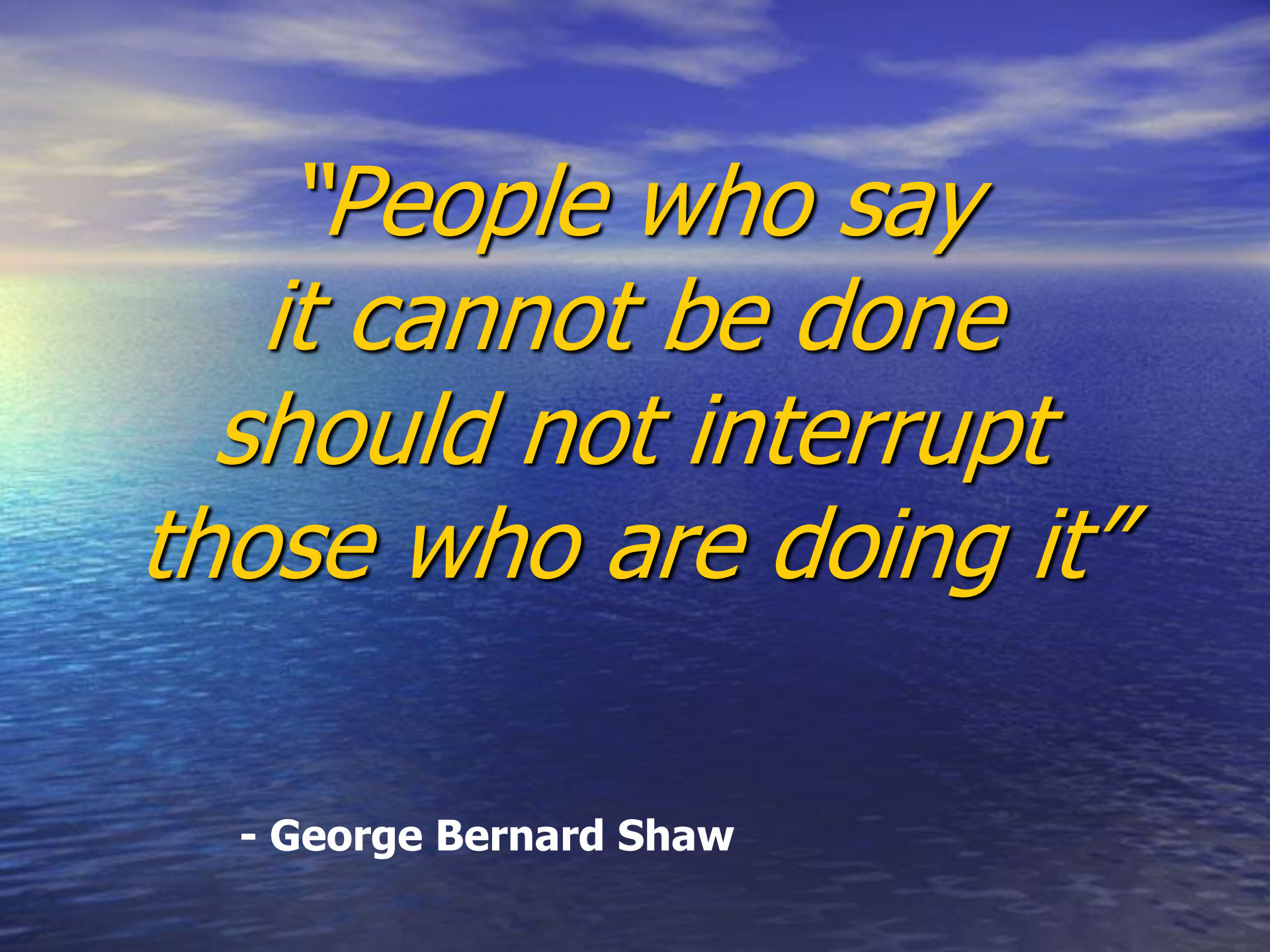
**This facility is
smoke free.**



Implementing Tobacco Treatment

Success vs. Failure

- NOT tobacco cessation – don't separate RECOVERY from substance use disorder
- Should be no different than cannabis use in the facility in someone with a severe alcohol use disorder
- The problem is not the drug of choice It is reliance on psychoactive substances to cope
- Tobacco use disorder treatment should be reflected in the:
 - Assessment
 - Treatment plan
 - Progress notes

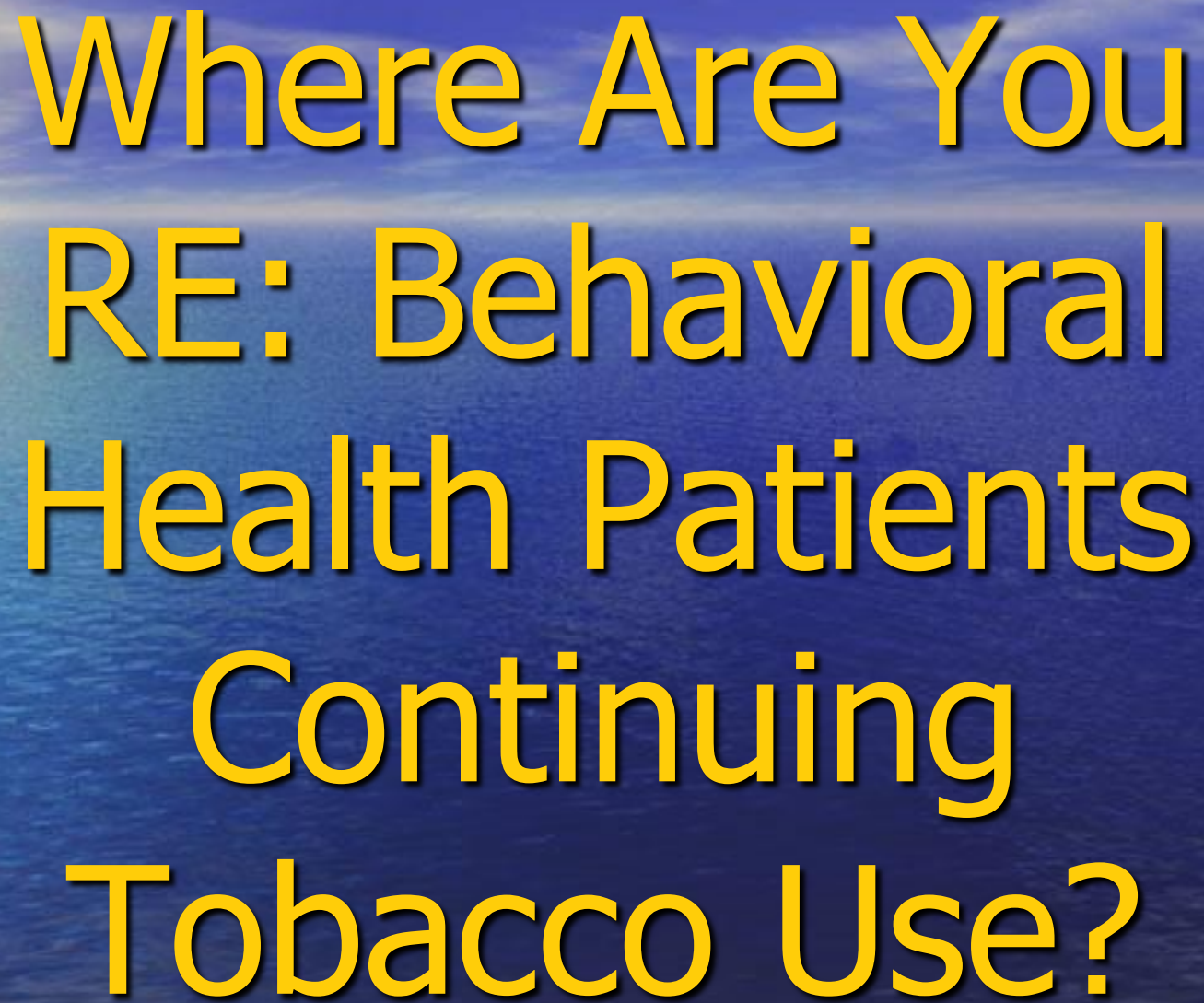


*"People who say
it cannot be done
should not interrupt
those who are doing it"*

- George Bernard Shaw

Smoking and Mental Health Disorders

- 2009-2011 among people with acute mental illness, 36.1% were current smokers compared with 21.4% of adults with no mental illness
- Tobacco use in patients in substance use treatment programs ranges from 65-97%

The background of the slide features a serene sunset scene over a vast ocean. The sky is a deep blue with wispy white clouds, and a vibrant rainbow arches across the horizon. The sun is partially visible on the left side, creating a bright, hazy glow that reflects on the water's surface. The overall atmosphere is calm and contemplative.

Where Are You
RE: Behavioral
Health Patients
Continuing
Tobacco Use?

Gambling Disorder

- One of most overlooked co-occurring disorders with substance use disorders
- Two item screen – “Lie-Bet” Screening Instrument
 - 1) Have you ever felt the need to bet more and more money?
 - 2) Have you ever had to lie to people important to you about how much you gambled?

Gambling Treatment Issues

- Most addiction treatment programs do not routinely screen for gambling disorders
- A major concern is that substance use and gambling disorder treatment is almost totally separate with separate and distinct programs and certifications, a lack of screening of one disorder when assessing for the other and even separate conferences.
- All of this is reminiscent of the split between substance use and mental health disorders of 30 years ago
- At very least, SUD treatment providers should at be screening for a co-occurring gambling disorder and if screened in, be prepared to refer to Gamblers Anonymous

ASAM's Special Populations

- Types of patients who are not well served by the ASAM Criteria
- Types of patients who clinicians find difficult in applying the criteria

Changes in the New ASAM Criteria

- Criteria more strength-based, empowering and recovery-oriented
- Section Tobacco Use Disorders
- Section on four Special Populations:
 - People in the criminal justice system
 - Older adults
 - Parents with children
 - People in safety-sensitive occupations
- No change in levels of care
 - Made consistent with SUD diagnoses in DSM-5
- Opioid Maintenance Treatment (OMT) now Opioid Treatment Services (OTS)
- NO changes in the adolescent criteria

Special Populations

People in the Criminal Justice System

- Includes individuals incarcerated, under community-based supervision such as correctional halfway houses or under probation or parole or participation in drug court programs
- Because of varying security levels, the ASAM Criteria may not have applicability
- Conflict frequently ensues because for treatment providers, recovery has the highest priority but for criminal justice, the highest priority is public safety
- Different priorities can be complementary by the artful application of the ASAM Criteria

Special Populations

People in the Criminal Justice System

- Goals of reduced/eliminated substance use, reduced recidivism and improvement in functional areas of the individual's life are often the same for both

Challenges

- Expecting movement through the Stage of Change in an inappropriately short time frame
- Judges determining length of stay and level of care instead of clinicians
- Due to limited resources, CJ system often has to make decisions based on what is available rather than offender's needs

Challenges

- CJ emphasis is on criminogenic Risk, Need and Responsivity (RNR) rather than SUD recovery
- CJ response to SUD treatment may be in conflict with CJ expectations (e.g., positive UA in treatment)
- High caseloads in CJ treatment
- More emphasis at discharge or transfer on Dimension 6 for offenders

Defining Recovery

- The referral from child welfare of an alcoholic father who abuses his children – now sober but still abusing his children
- The referral from drug court who no longer uses drugs and is now drug free allowing him to better use his criminal skills
- CAUTION: Demand from judge that an offender caught selling drugs who is not addicted and may not even use drugs, be admitted to your program

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- Opioid Maintenance Treatment (OMT) now Opioid Treatment Services (OTS)

Special Populations

Older Adults

- Many of the criteria in the DSM-5 for a diagnosis of a Substance Use Disorder may not be applicable to older adults
- This inapplicability will at least skew severity downward resulting in inappropriate placement

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It Is Possible:

- That an older adult cannot meet more than 3 of the 11 criteria
- Would limit severity to Mild

Special Populations

Older Adults

- Because of mobility problems, treatment settings and recovery group attendance can present problems
- Many older adults do not drive at all at night (12 step meetings)
- Reimbursement restrictions (e.g., Medicare does not reimburse for residential treatment)

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- No change in levels of care
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- Opioid Maintenance Treatment (OMT) now Opioid Treatment Services (OTS)

Special Populations

Parents with Children

- Note: NOT women with children
- Includes pregnant, post-partum women, custodial parents, both men and women and non-custodial parent
- Specially designed programs including *programming* for children
- Any level of care
- Dimension 6 is key

In Addition to Treatment May Require

- Basic instruction on how to care for a child
- Help with bonding to the child
- Parent effectiveness training
- Post-treatment safe housing

Changes in the New ASAM Criteria

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Special Populations

Persons in Safety-Sensitive Occupations

- Have a responsibility to the public
 - Have the potential for serious harm to others because of their impairment
 - Implied public trust in their occupation
- These two factors color decision about type of treatment, setting and length of treatment
- Aggressive treatment and continued monitoring do more than assure safety of public at large
 - e.g., a police officer who relapses may have an adverse effect on public safety, peers, the department, government officials and public opinion may reactively punish subsequent officers

Special Populations

Persons in Safety-Sensitive Occupations

- Examples of safety-sensitive workers include:
 - physicians & nurses
 - veterinarians and animal workers
 - other healthcare professionals
 - truck and bus drivers; railroad engineers
 - pilots
 - attorneys
 - nuclear plant workers
 - police officers
 - psychologists, social workers, A & D counselors

The Issue of A & D Counselors Who Relapse

- Two years of sobriety as a requirement for the position
- “Giving something away you don’t (yet) have?”
- Patients with longer abstinence that counselor
- Issues of the Americans with Disability Act?

Special Considerations

- Healthcare workers have access to drugs, sometimes the very drugs they used
- Undercover police officers have access to gray and black market drugs as may attorneys
- Healthcare workers commonly have difficulty adopting the role of “patient”
 - The more responsibility the person has in his or her day-to-day life, the more difficulty

Treatment Issues

- Healthcare workers work in a “hostile” environment and they need to develop refusal skills
- Safety sensitive workers should discontinue work and should not go back until:
 - Public risk issues have been addressed
 - All work regulations, licenses and legal issues have been addressed and a permit to return to work

Treatment Issues (cont.)

- Safety sensitive workers should discontinue work and should not go back until:
 - Work cues and triggers have been delineated and a management plan is in effect
 - The work environment has made appropriate alterations to maximally encourage to sustained recovery. . . Especially true for those who have steady personal access to their previously addictive drugs
 - Supervisory personnel have training to address profession-specific workplace issues

Treatment Issues (cont.)

- Need professional-specific therapy groups in order to talk openly and to resist the role of “junior therapist”
- Need professional-specific support groups
- Should address pragmatic, logistical and emotional problems the patient will face in recovery including possibility of no income for an extended period of time
- Long term follow up and body fluid or or tissue analysis

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Levels of Care

Overall Structure of Levels of Care & Service

- Level 0.5 – Early Intervention
- Level 1 - Outpatient
- Level 2 - Intensive Outpatient/Partial Hospitalization
- Level 3 – Residential/Inpatient Treatment
- Level 4 - Medically Managed Intensive Inpatient Treatment

Level 0.5 - Early Intervention

- Assessment and Education services for individuals with problems or risk factors related to substance abuse, but for whom an immediate substance abuse disorder cannot be confirmed
- Further assessment is warranted to rule a substance use disorder in or out
- If a client is confirmed to meet a DSM Substance Abuse or Dependence disorder, and treatment is indicated, then client would receive specific addiction treatment at Level I or higher
- An example might be an individual convicted of DUI

Level 0.5 is NOT a level of care or treatment

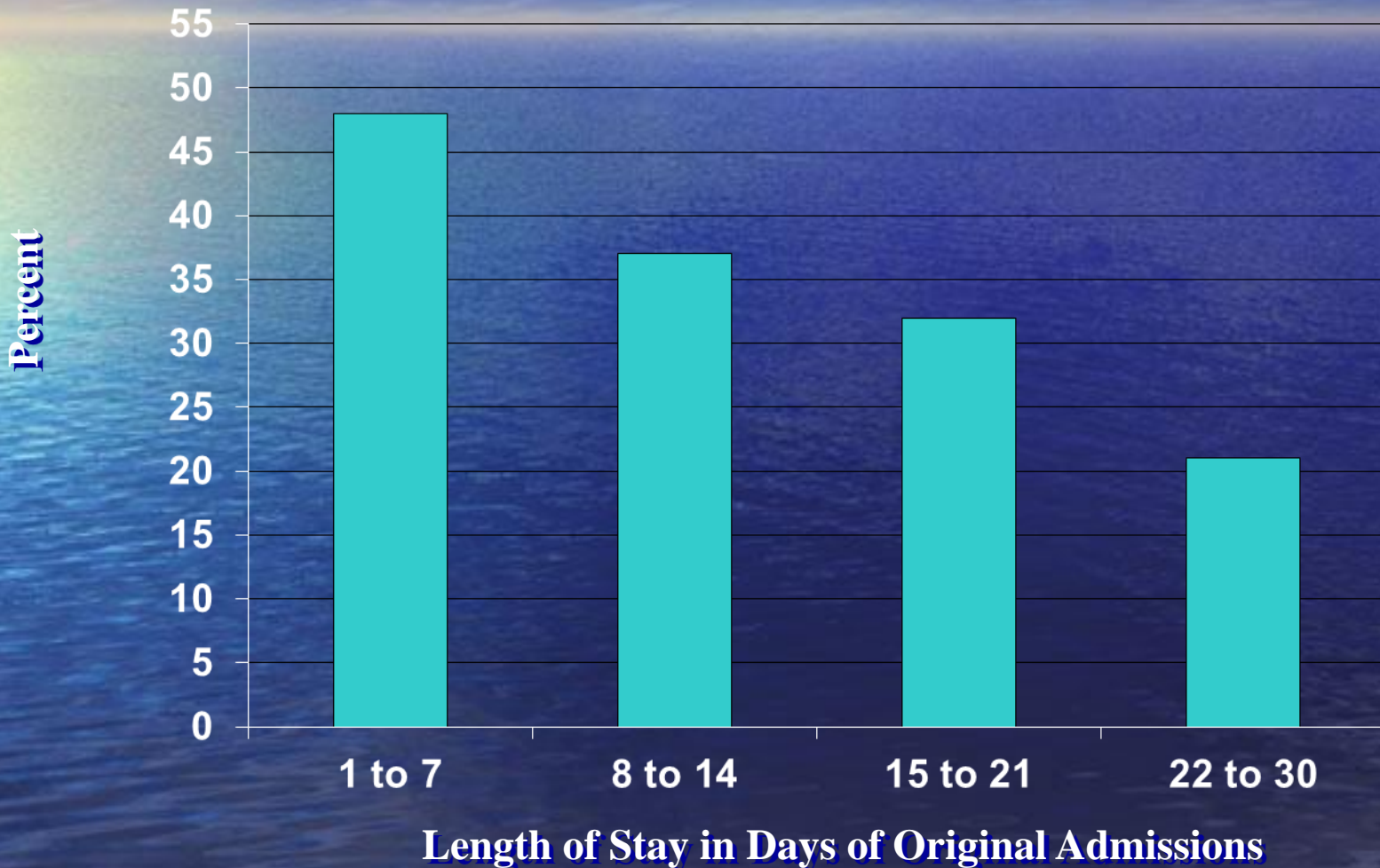
but the combination of psychoeducation and assessment. If the assessment indicates the need for treatment, the individual may receive treatment at the conclusion of the 0.5 service or concurrently

On Length of Treatment

- ASAM does not specify length of treatment for any level of care
- Therefore, there are no fixed length programs – no 30 day inpatient, 60 day residential or 20 session IOP programs!
- Patients length of treatment is determined by when they meet their treatment plan goals and objectives
- It is clinically inappropriate to determine length of treatment by the calendar
- The one exception is Level 0.5 DUI programs whose length is determined by state legislation

Length of Stay and Readmission

Readmission To Treatment Within One Year



Outpatient Levels of Care & Service

- Level 0.5 – Early Intervention
- Level 1 - Outpatient
 - Less than 9 Contact Hours/Week
- Level 2 - Intensive Outpatient/Partial Hospitalization
 - ❖ Level 2.1 - 9 or More Contact Hours/Week in a *Structured* Program (6 hrs. for adolescents)
 - ❖ Level 2.5 - 20 or More Contact Hours/Week in a *Structured* Program

Intensity

- Intensity in the outpatient levels is determined by time, e.g., minimum of 9 hours, 20 hours, etc.
- Intensity in residential levels is determined by patient needs and services provided

Residential/Inpatient Levels of Care

- Level 3: Residential/Inpatient Services
 - Level 3.1- Clinically Managed Low-Intensity Residential Services (e.g. halfway house)
 - Level 3.3- Clinically Managed, Population-Focused, High-Intensity Residential Services (e.g., *Therapeutic Rehabilitation Facility*)
 - Level 3.5- Clinically Managed High-Intensity Residential Services (e.g., therapeutic community, *Residential Treatment Center*)
 - Level 3.7- Medically Monitored Intensive Inpatient Treatment
- Level 4: Medically Managed Intensive Inpatient Treatment

Level 3.1 vs. Supportive Living

- Level 3.1 is a Level of CARE
- Must offer a minimum of 5 hours of treatment/week
- If adolescent, likely to offer more
- In contrast, supportive living is just that – no provision of treatment – room and board and peer support
- The Florida Model

Residential/Inpatient Levels of Care

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 - Level 3.7- Medically Monitored Intensive Inpatient Treatment
- Level 4: Medically Managed Intensive Inpatient Treatment

Why the Change in Name?

- Previously called “Clinically Managed Medium-Intensity Residential Services”
- While never meant that way, many users viewed Level 3.3 as an intermediate step in intensity between a 3.1 and a 3.5

Why the Change in Name?

- It is actually a level of care specifically designed for patients with acute or chronic cognitive deficits
- Examples include:
 - early dementia
 - cognitive deficits associated with psychosis
 - traumatic brain injuries
 - acute brain syndrome
 - chronic brain syndrome
- In order to respond to the cognitive deficits, treatment is slower-paced, more repetitive and more concrete

Residential/Inpatient Levels of Care

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Description

- High intensity services without a medical component
- For patients who have significant deficits in coping skills, may have a history of abuse, come from very chaotic home environments, may have criminal histories, may have antisocial values (possibly meeting criteria for Antisocial Personality Disorder)
- Originally came from the Therapeutic Community model

Issues

- Commercial insurance often more willing to reimburse than for inpatient
- In publically funded programs, significantly over-utilized, most frequently because the individual is homeless
- YOU DON'T TREAT HOMELESSNESS!
- In publically funded programs, there is often inappropriately long lengths of stay because:
 - state description of level of care includes length of stay
 - consideration of the old TC model

Residential/Inpatient Levels of Care

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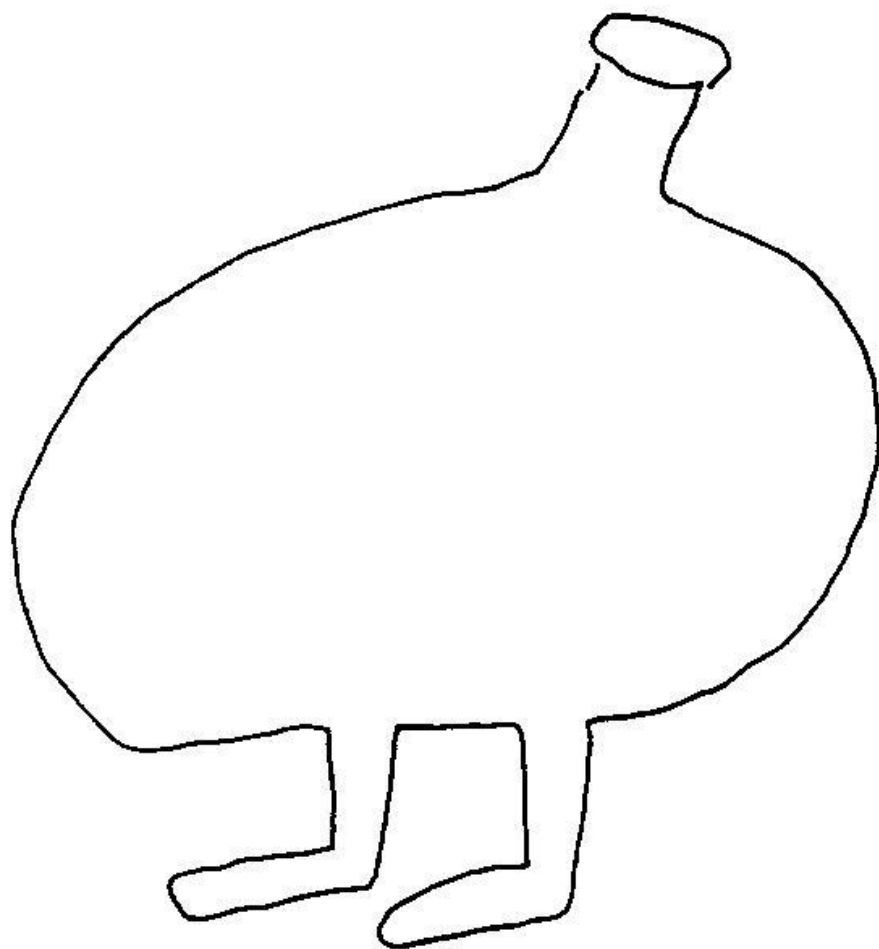
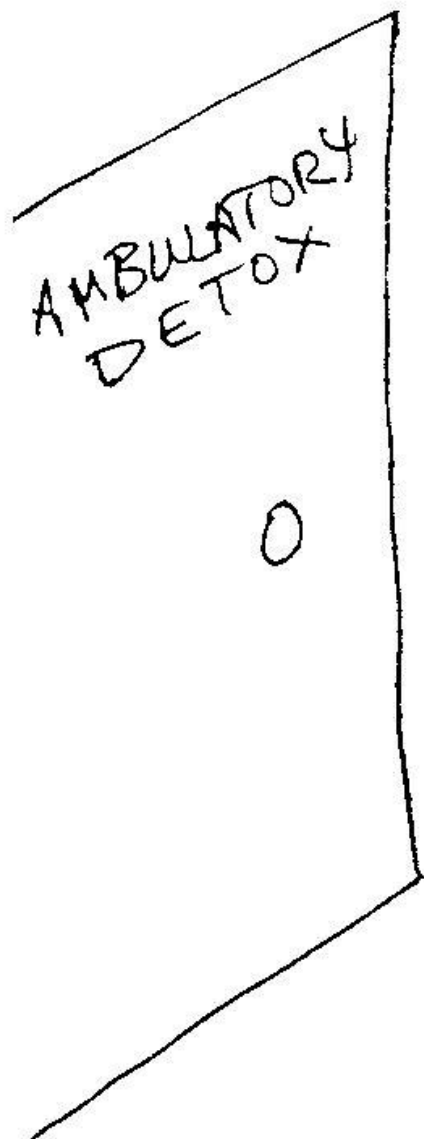
Level 3.7 & 4

- Both are medical but Level 3.7 medically *monitored* (physician involved) while Level 4 is medically *managed* (physician managed)
- Level 3.7 requires 24 hour RN service
- Level 3.7 may be free standing or in a hospital while Level 4 must be in a licensed hospital
- The disappearance of Level 4 programs

ASAM Criteria

(Dimension 1 - Detoxification Services)

- Level 1-WM: Ambulatory Detoxification without Extended On-site Monitoring (e.g., physician office practice/home health care)
- Level 2-WM: Ambulatory Detoxification with Extended on-site Monitoring (e.g., detoxification on a partial hospitalization program)
- Level 3-WM: Residential/Inpatient Detoxification
 - Level 3.2-WM: Clinically Managed Residential Detoxification (e.g., social detox)
 - Level 3.7-WM: Medically Monitored Inpatient Detoxification
- Level 4-WM: Medically Managed Inpt. Detoxification



GEORGE'S
LIVER
GOES
TO
DETOX



©Aurelio Santarelli 2000

**In a little known annex of the Betty Ford Clinic,
discarded tequila worms dry out.**

OMT ---> OTS

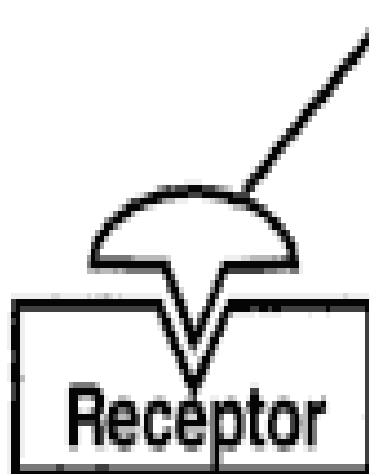
- In the PPC-2R, Opioid Maintenance Treatment (OMT) referred specifically to methadone maintenance
- Since that time, there have been other agonist drugs developed, e.g., buprenorphine, (in its two form Subutex and Suboxone) and development and increasing use of antagonist drugs, e.g., oral naltrexone, extended release, injectable naltrexone (Vivitrol) and acamprosate (Campral)
- Opioid Treatment Services (OTS) which replaces OMT includes both agonist and antagonist drugs

Agonist

Heroin



Methadone

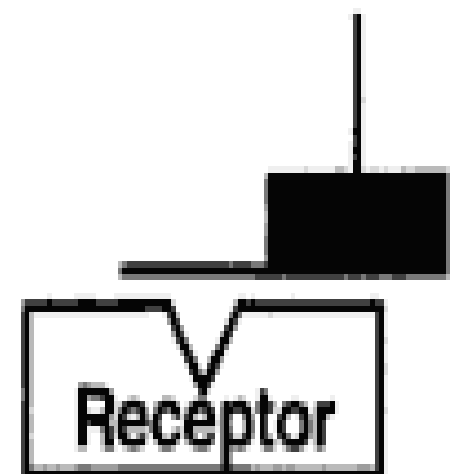


Antagonist

Heroin



Naltrexone



Agonist Treatment Can Be Further Broken Down

- Opioid Treatment Program (OTP)
 - An example of this would be the classic methadone maintenance program (although many are also now using buprenorphine as well)
 - These are heavily regulated by federal agencies
 - Although methadone can be prescribed by any licensed physician for the treatment of opioid withdrawal or the management of pain, only an OTP can dispense it for maintenance

Agonist Treatment Can Be Further Broken Down

- Office-Based Opioid Treatment (OBOT)
 - An office-based practice in which the physician can prescribe buprenorphine or any of the antagonist drugs
 - In order for the physician to prescribe buprenorphine he or she must go through an 8-hour training course
 - There is a 30-patient limit but the DEA can authorize 100 patients after the first year

If you are on methadone or buprenorphine, you're still addicted

- *Incorrect*
- Still addicted means
 - compulsion
 - loss of control
 - continued use in spite of adverse consequences
 - craving
- Remain physiologically dependent

Other Changes in the New ASAM Criteria

- Re-ordered to be more user-friendly and follow the flow from Historical Foundations to Guiding Principles to Assessment, Service Planning and Placement decisions
- ADOLESCENT CRITERIA NO LONGER SEPARATE/STAND-ALONE: consolidated Adult and Adolescent content to minimize redundancy while preserving adolescent-specific content
- Section on working with managed care
- Updated Dimension 1 information reflecting more recent research

Changes in the New ASAM Criteria

- Change in title

From:

“The ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders”

To:

“The ASAM Criteria: Treatment Criteria for Substance and Co-Occurring Conditions”

- New level of care numbering system from Roman to Arabic numbers (e.g. Level II > Level 2)
- Change in name of Level 3.3 from Clinically Managed, Medium Intensity Residential Services to Clinically Managed, Population- Focused, High-Intensity Residential Services”

Individualized Treatment

- The Four Ps
 - Participant Assessment
 - Patient Problems/Priorities
 - Plan
 - Progress
- Match *Severity or Level of Functioning* (Assets and Obstacles to Improvement) With *Intensity of Service* (Treatment Modalities, Strategies and Site of Care)

Individualized Treatment



PATIENT ASSESSMENT

Data from all
BIOPSYCHOSOCIAL
Dimensions

PRIORITIES

BIOPSYCHOSOCIAL Severity (SI)
and level of Functioning (LOF)

SERVICE PLAN

BIOPSYCHOSOCIAL Treatment
Intensity of Service (IS) - Modalities and Levels of Service

PROGRESS

Response to Treatment
BIOPSYCHOSOCIAL Severity (SI)
and Level of Functioning (LOF)

PLACEMENT



ASAM Criteria Dimensional Assessment

Dimensional Criteria Assessment

- Dimension 1: Acute Intoxication/Withdrawal Potential
- Dimension 2: Biomedical Conditions & Complications
- Dimension 3: Emotional/Behavioral/Cognitive Conditions & Complications
- Dimension 4: Readiness to Change
- Dimension 5: Relapse/Continued Use/Continued Problem Potential
- Dimension 6: Recovery Environment

Dimension 1

Change in Language

The term “Detoxification” changed to
“Withdrawal Management”

- Livers detoxify patients
- Clinicians manage the process

ASAM Criteria, Dimension 1: Detoxification/Withdrawal Potential

- **Sample Questions**

- Are there current signs of withdrawal?
- Does the patient have supports to assist in ambulatory detoxification if medically safe?
- Has the patient been using multiple substances in the same drug class?
- If the withdrawal concern is about alcohol, what is the patient's CIWA-Ar score?
- When was the substance(s) last used?

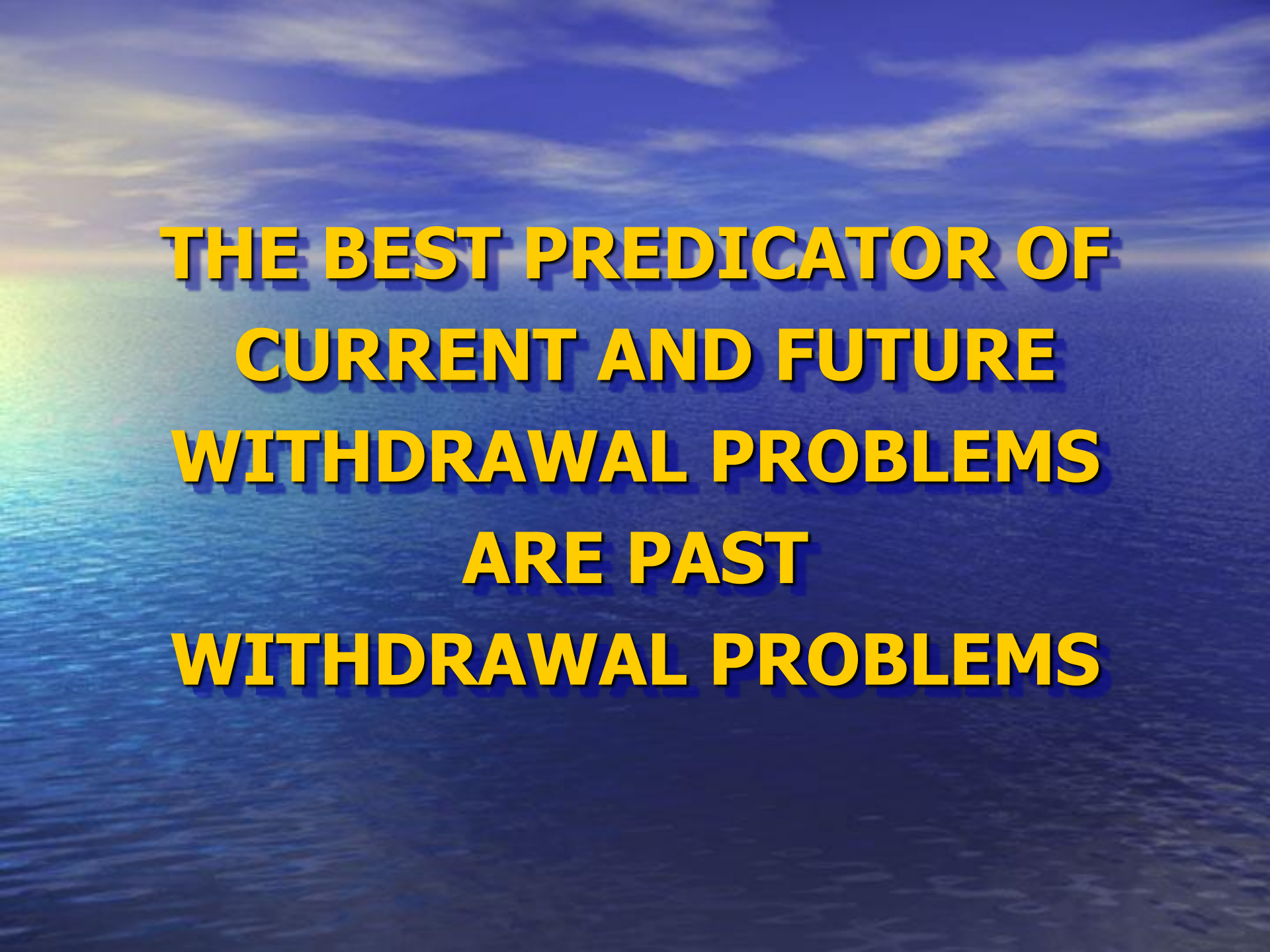
Three Goals for Dimension 1

- Avoidance of potentially hazardous consequences of discontinuation of drugs of dependence
- Facilitation of the patient's completion of detoxification and timely entry into continued treatment
- Promotion of patient dignity and easing discomfort during the withdrawal process

Drug and Alcohol History

Drug Name	Route of Administration	First Use	First Problem	Amount	Frequency	Last Use	Tolerance

Drug of Choice: _____ Longest Abstinence: _____ When: _____ Circumstances: _____



**THE BEST PREDICATOR OF
CURRENT AND FUTURE
WITHDRAWAL PROBLEMS
ARE PAST
WITHDRAWAL PROBLEMS**

The CIWA-Ar

(Clinical Institute Withdrawal Assessment of Alcohol, Revised)

- It requires under two minutes to administer
- It requires no medical knowledge
- It provides you with a quantitative score that predicts the severity of withdrawal from alcohol

Addiction Research Foundation Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar)

NAUSEA AND VOMITING: Ask
“do you feel sick to your
stomach? Have you vomited?”
Observation

- 0 No Nausea and no vomiting
- 1 Mild Nausea with no vomiting
- 2
- 3
- 4 Intermittent nausea with dry heaves
- 5
- 6
- 7 Constant nausea, frequent dry heaves and vomiting

TREMOR: Arms extended and
fingers spread apart.
Observation

- 0 No tremor
- 1 Not visible but can be felt fingertip to fingertip
- 2
- 3
- 4 Moderate, with patient's arm extended
- 5
- 6
- 7 Severe, even with arms not extended

ASAM Criteria Dimension 2:

Biomedical Conditions and Complications

- **Sample Questions**

- Are there current physical illnesses other than withdrawal, that need to be addressed or which complicate treatment?
- Are there chronic illnesses which might be exacerbated by withdrawal, e.g., diabetes, hypertension?

ASAM Criteria Dimension 2: Biomedical Conditions and Complications (Cont.)

- **Sample Questions**

- Is there a need for medical services which might interfere with treatment (e.g., chemotherapy or kidney dialysis)?
- Are there conditions which might interfere with treatment (e.g., chronic pain with narcotic analgesics, pain associated with acute pancreatitis)?

Two Types of Medical Conditions and Complications

- Conditions which place the patient at Risk (e.g., esophageal varices, unstable hypertension or diabetes)
- Conditions which interfere with treatment (e.g., the need for kidney dialysis, chronic pain, pain from acute pancreatitis)

When thinking co-occurring . . .

Think also medical co-occurring

- HIV/AIDS
- Hepatitis B
- Hepatitis C
- Pregnancy

ASAM Criteria Dimension 3:

Emotional/Behavioral/Cognitive Conditions and Complications

- Sample Questions
 - Are there current psychiatric illness or psychological, behavioral or emotional problems that need to be addressed or which complicate treatment?
 - Are there chronic conditions that affect treatment?
 - Do any emotional/behavioral problems appear to be an expected part of addiction illness or do they appear to be separate?

ASAM Criteria Dimension 3: Emotional/Behavioral/Cognitive Conditions and Complications (Cont.)

- Sample Questions
 - Even if connected to addiction, are they severe enough to warrant specific mental health treatment?
 - Do any emotional/behavioral problems identified appear to be more consistent with the adolescent's developmental level than an mental health problem?

ASAM Criteria Dimension 3: Emotional/Behavioral/Cognitive Conditions and Complications (Cont.)

- Sample Questions
 - Is the patient suicidal, and if so, what is the lethality?
 - If the patient has been prescribed psychiatric medications is he/she compliant?

Co-Occurring Disorders

- Depending on the group, co-occurring disorders range up to 10x what is found in community samples, with corrections and methadone populations being the highest
- In general, it is estimated that 50 – 60 of persons with a SUD have a co-occurring mental health disorder
- In general, it is estimated that 35 – 50 of persons with a mental health disorder have a co-occurring SUD

**TODAY, EVERY PROGRAM TREATS
PATIENTS
WHO HAVE CO-OCCURRING DISORDERS
BUT
HOW MANY PROVIDERS ARE TREATING
BOTH
THE ADDICTION
AND
THE PSYCHIATRIC COMORBIDITY?**

**When Co-Occurring Addiction and Mental
Health Disorders Exist,
Treating Either Without the Other
Will Lead to Successful Outcome When:**



ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD)

- Incidence in the General Population is: 2.3%
- Incidence in a cocaine using population is: 32-34%
- Up to 15% of adults with ADHD will still meet full criteria by age 25
- Up to 65% of adults with ADHD will still meet in “partial remission” criteria by age 30
- Rate of ADHD are higher among people with SUDs

dribbleglass.com



*So much easier
than parenting.*

RITALIN

CLARKSON SYSTEMS

Extra Strength **RITALIN**

THE CHEMICAL LOBOTOMY!

TABLETS

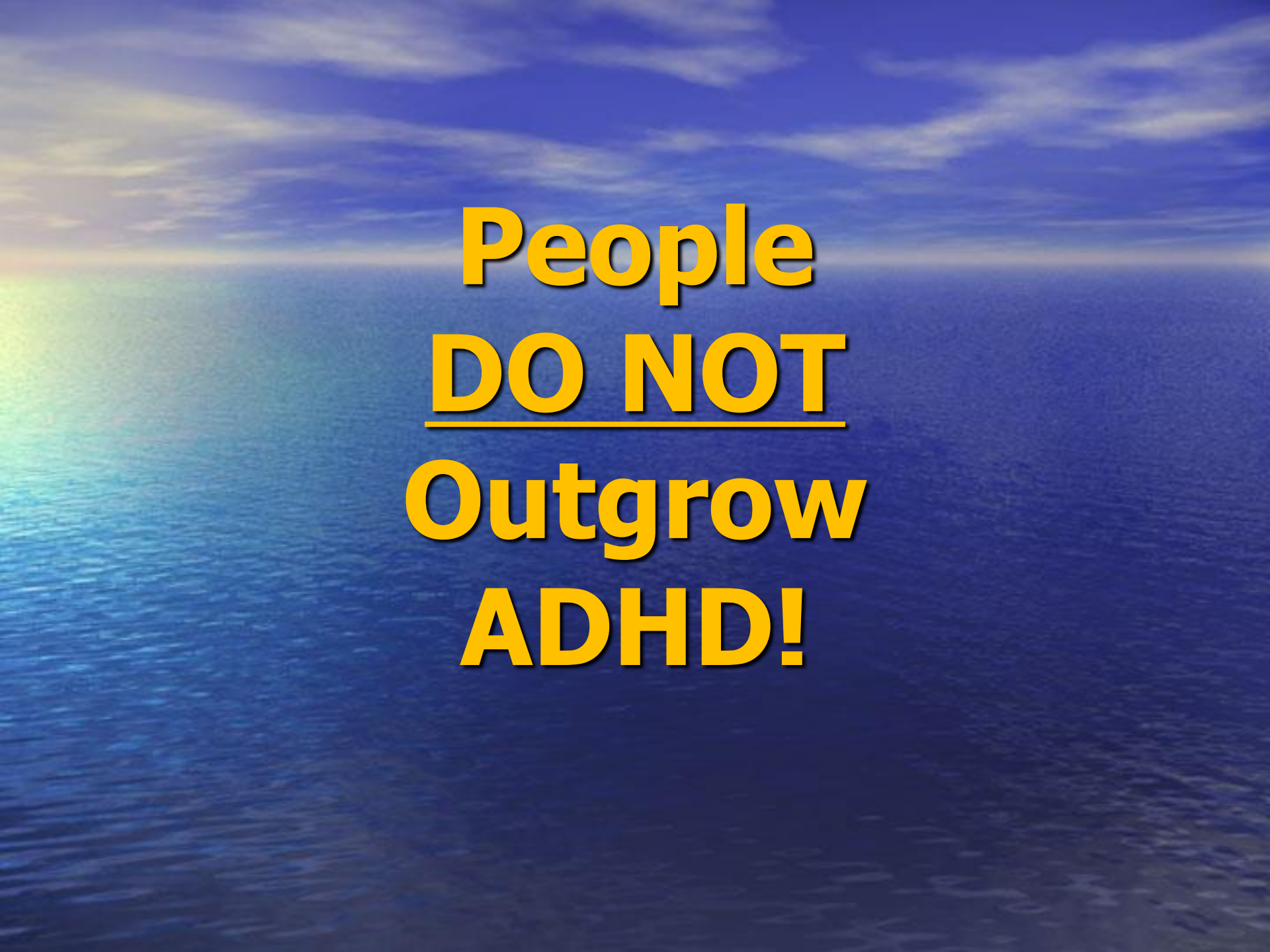


500 mg each

Novartis Pharmaceuticals Corp.

seen at www.watchersweb.com

Because the American Psychiatric Association and the National Institute of Mental Health have decided that childhood is a Mental Disease.



**People
DO NOT
Outgrow
ADHD!**



When

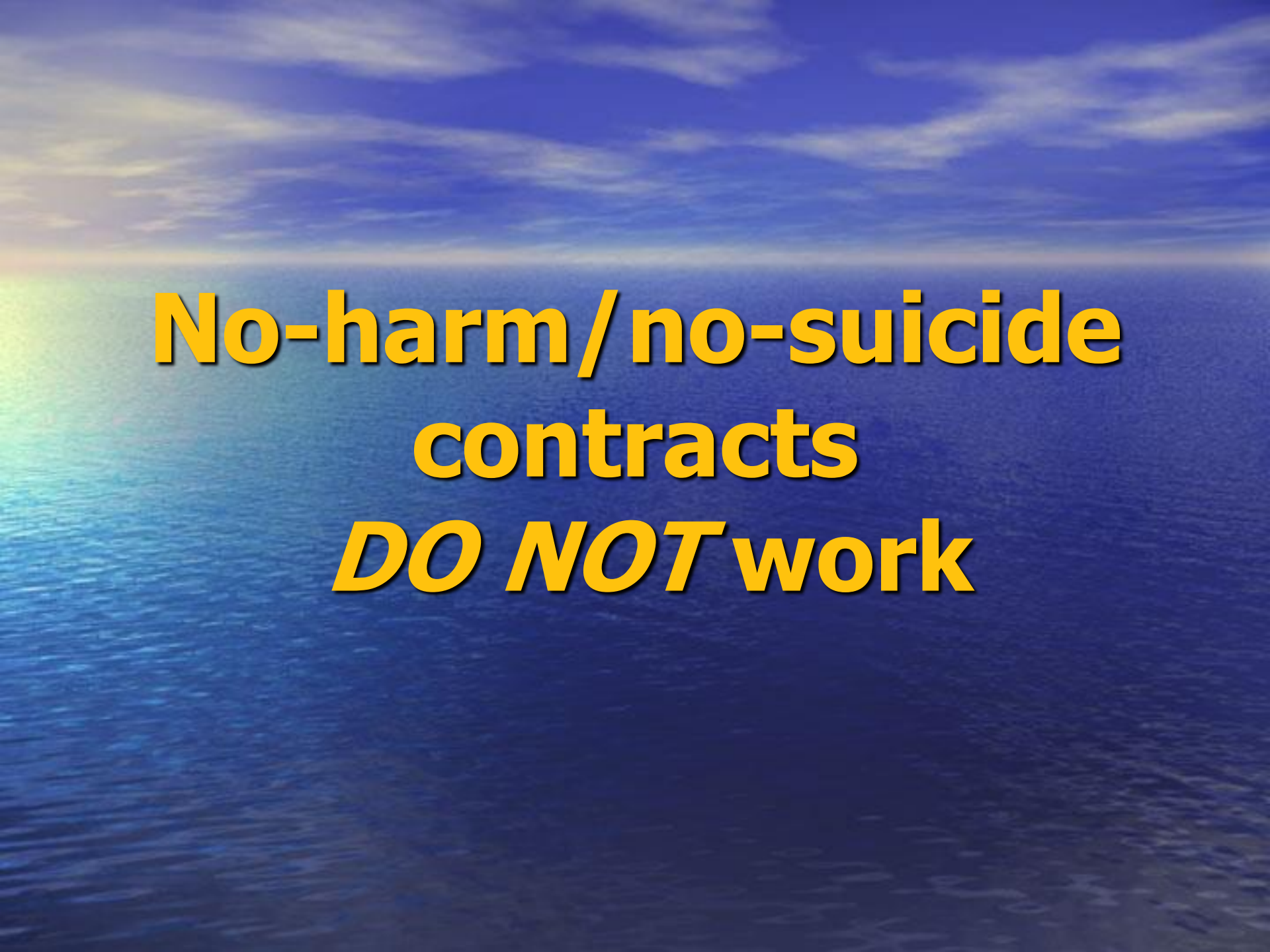
eHarmony

goes wrong

IMASAPHOTO.COM BY 🐾 & 🐾

Part of the General Dimension 3 Assessment Includes:

- **Assessment of suicidality**
 - Factors associated with a higher risk for suicide
 - ✓ White, male over 65
 - ✓ Major depression, bipolar disorder
 - ✓ Previous suicide attempts
 - ✓ Family history of suicide
 - ✓ Plan, means & opportunity
 - ✓ Access and comfort with a lethal means of suicide (e.g., firearms)
 - ✓ In treatment



**No-harm/no-suicide
contracts
DO NOT work**

The Existence of a *Psychiatric
Diagnosis Alone*

Is Not Predictive

Of Ability to Utilize Any Particular
Intensity or Type of Treatment

Without an Assessment Of

Level of

Psychiatric Functioning

Mental Health Problem and Mental Health Disorders

- Mental health problems exist on a continuum which includes sub-diagnostic threshold symptoms and traits
- At some point there are enough symptoms and traits to meet diagnostic criteria
- In common use, “mental health problems” includes both sub-threshold and diagnosable problems
- Generally, the more criteria an individual meets beyond what is necessary to meet the diagnosis, the more severe the problem
- It is not reasonable to assume that a new admission has no mental health problems

Anger Management Problems

Anger management:

When angry with someone,
it helps to sit down and
think about the problem...



The New Paradigm for Co-Occurring Disorders

Characteristics of Co-Occurring Disorders

PATIENTS

Addiction-Only Patients:

Individuals who exhibit substance abuse or dependence problems without co-occurring mental health problems or diagnosable Axis I or II disorders

SERVICES

Addiction Only Services

(AOS) - Services directed toward the amelioration of substance related disorders without services for the treatment of co-occurring mental health problems or diagnosable disorders. Such services are clinically inappropriate for dually diagnosed individuals

The New Paradigm for Co-Occurring Disorders

Characteristics of Co-Occurring Disorders

PATIENTS

**Patients with Co-Occurring
MH Problems of moderate
to High Severity:**

Individuals who exhibit diagnosable Axis I or II disorders, who are not stable and require mental health as well as addiction treatment

SERVICES

Co-Occurring Enhanced (COE):

Psychiatric services available on site or closely coordinated; all staff are cross-trained in addiction and mental health and are competent to understand and identify signs and symptoms of acute psychiatric conditions and treat mental health problems along with the substance use disorders. Treatment for both MH & SA disorders are integrated. This service is most similar to a traditional “dual diagnosis” program.

The New Paradigm for Co-Occurring Disorders

Characteristics of Co-Occurring Disorders

PATIENTS

Patients with Co-Occurring MH Problems of mild to moderate Severity:

Individuals who exhibit (1) sub-threshold diagnostic (e.g., traits, symptoms) of mental health disorders or (2) have diagnosable but stable disorders (e.g., bipolar disorder but compliant with, and stable on lithium)

SERVICES

Co-OccurringCapable (COC):

Primary focus on substance use disorders but capable of treating patients with sub-threshold or diagnosable but stable mental health disorders. Psychiatric services available on site or by consultation; at least some staff are competent to understand and identify signs and symptoms of acute psychiatric conditions

The New Paradigm for Co-Occurring Disorders

Characteristics of Co-Occurring Disorders

PATIENTS

Patients with Co-Occurring MH Problems of moderate to High Severity:

Individuals who exhibit diagnosable disorders, who are not stable and require mental health as well as addiction treatment

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The New Paradigm for Co-Occurring Disorders

Characteristics of Co-Occurring Disorders (Shulman Modification)

- **Patients with Co-Occurring Chronic and Debilitating Mental Illness:** *Individuals who exhibit severe and persistent mental illness which chronically limits their ability to function independently in the community because of their mental health and addiction problems. They require continuous care and case management in the community in which they live in order to function and avoid rehospitalization. Total restoration of function is less likely than with patients with co-occurring MH problems of moderate to high severity.*
- **Co-Occurring Enhanced (COC with ACT & CM):** *Psychiatric and addiction assertive community treatment services and case management are provided to the patients in the community in which they live as part of an empathic, continuous, hopeful, treatment relationship in which integrated treatment and coordination of care can take place through multiple treatment episodes.*

Four Quadrant Model

Quadrant 1

Less severe mental disorder/less severe substance disorder

Quadrant 2

More severe mental disorder/less severe substance disorder

Quadrant 3

Less severe mental disorder/
more severe substance disorder

Quadrant 4

More severe mental disorder/
more severe substance disorder

Dimension 3 ***Adolescent Subdomains***

A subdomain
is an assessment subcategory
within
Dimension 3
(Emotional, Behavioral or Cognitive
Problems),
as described below:

Subdomains

- 1) Dangerousness/Lethality
- 2) Interference with Addiction Recovery Efforts
- 3) Social Functioning
- 4) Ability for Self-Care
- 5) Course of Illness

Adolescent Subdomain Description

Dangerousness/Lethality:

- Impulsivity with regard to homicide, suicide or other behaviors that pose a risk to self or others and/or to property;
- Seriousness and immediacy of the individual's ideation, plans and behavior
- Ability to act on such impulses

Interference with Addiction Recovery Efforts:

- Degree to which patient is distracted from addiction recovery efforts by emotional, behavioral and/or cognitive problems;
- Conversely, the degree to which the patient is able to focus on addiction recovery.

Adolescent Subdomain Description

Social Functioning:

- Degree to which an individual's relationships are affected by his or her substance use and/or other emotional, behavioral and cognitive problems;
- Look at ability to cope with:
 - Friends
 - Significant others or family
 - Vocational or educational demands
 - Ability to meet personal responsibilities

Ability for Self-Care:

- The degree to which an individual can perform activities of daily living;
- Look at such things as:
 - Personal grooming
 - Obtaining food and shelter

Adolescent Subdomain Description

Course of Illness:

- Employs the history of the patient's illness and response to past treatment to help to interpret the patient's current signs, symptoms and presentation;
- To predict the patient's likely response to future treatment;
- Assess interaction between chronicity and severity of current difficulties

“IMMINENT DANGER”

1. A strong probability that certain behaviors will occur (e.g., continued alcohol or drug use or relapse or non-compliance with psychiatric medications)
2. The likelihood that these behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in a consistent pattern of driving while intoxicated or non-compliance with neuroleptic medications in someone psychotic)
3. The likelihood that such adverse events will occur in the very near future

In order to constitute “imminent danger,” ALL THREE ELEMENTS must be present

ASAM Criteria, Dimension 4: Readiness to Change

- Sample Questions

- Does the patient feel coerced into treatment or actively object to receiving treatment?
- How ready is the patient to change (stage of “readiness to change”*)?
- If willing to accept treatment, how strongly does the patient disagree with others’ perception that s/he has an addiction problem?

* Stage of change should be documented in each progress note

ASAM Criteria, Dimension 4: Readiness to Change

- Sample Questions

- Is the patient compliant to avoid a negative consequence (externally motivated) or internally distressed in a self-motivated way about his/her alcohol or other drug use problems?
- Is there leverage available?



“Resistance
is
Ambivalence
in Drag”

BEFORE 6 BEERS



AFTER 6 BEERS

AFTER 6 BEERS



BEFORE 6 BEERS

RESISTANCE & NON-COMPLIANCE

Are characteristic of all chronic illnesses/disorders,
not only substance use disorders!!

EXTERNAL vs. INTERNAL MOTIVATION

(Motivation to Enter Treatment
vs.
Motivation to Recover)

RESISTANCE & NON-COMPLIANCE

Are characteristic of all chronic illnesses/disorders,
not only substance use disorders!!

The Resistance/Confrontation Escalator

CONF-
RESIST
CONFRONT-
RESISTANC-
CONFRONTATA-
RESISTANCE

CONFRONTATION RESISTANCE

CONFRONTATION RESISTANCE →

CONFRONTATION RESISTANCE →

CONFRONTATION RESISTANCE →

Higher Resistance and Denial
Do Not ALONE

**Indicate the Need for,
or Clinical Appropriateness Of
A Higher Intensity Level of
Treatment**

**EVERY patient
who presents for
assessment or
treatment is
motivated!**

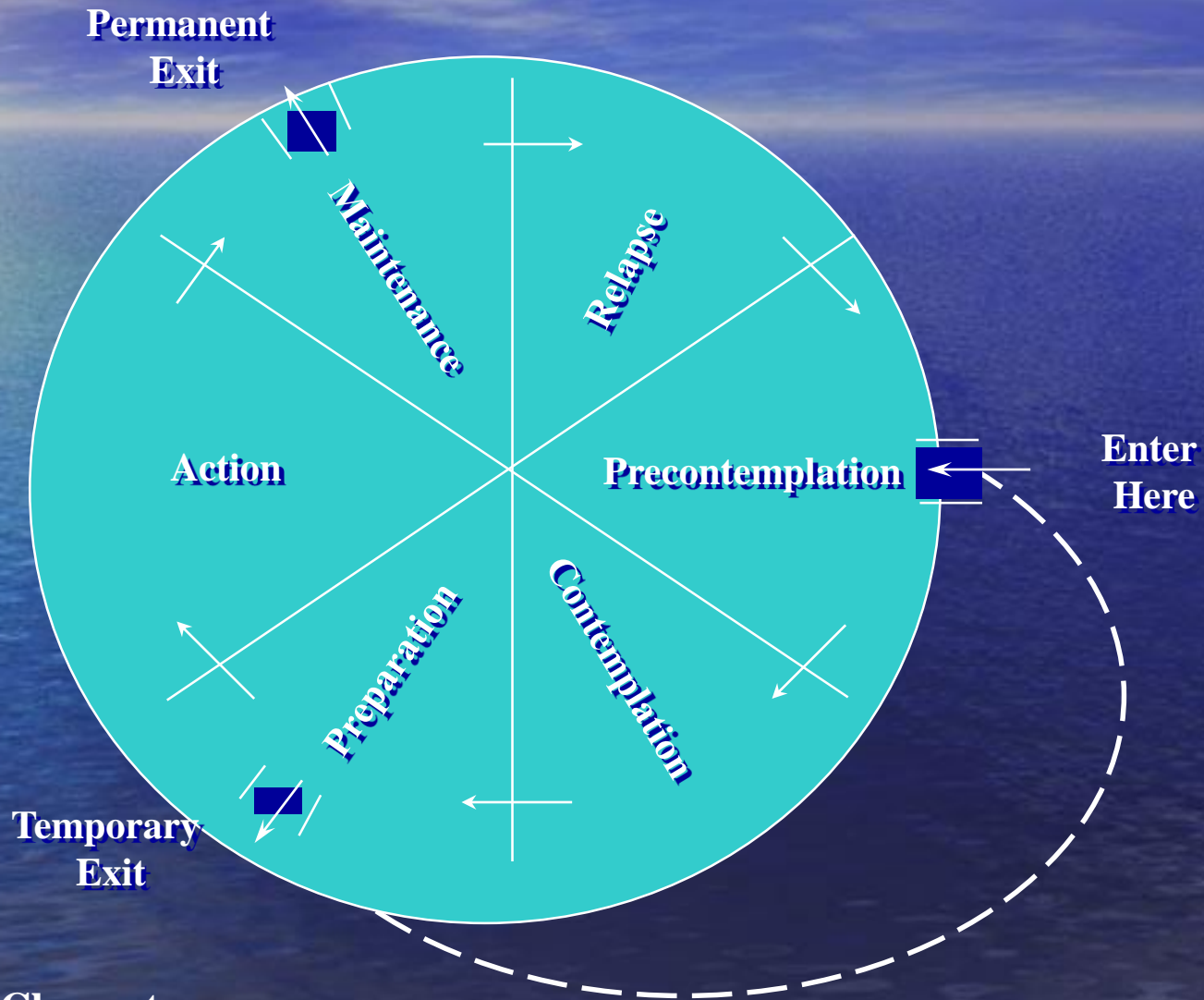
© 1997 Randy Glasbergen.
E-mail: randy@glasbergen.com
www.glasbergen.com



Transtheoretical Stages of Change (Prochaska & DiClemente)

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse and Recycling
- Termination

Stage Model of the Process of Change



PRE-CONTEMPLATION

- Not yet considering the possibility of change although others are aware of the problem
- Active resistance to change
- Seldom appear for treatment without coercion
- Could benefit from non-threatening information and strategies to raise awareness of a possible “problem” and the possibilities for change

CONTEMPLATION

- Ambivalent, undecided, vacillating between whether he/she really has a “problem” or needs to change
- Wants to change, but this desire exists simultaneously with resistance to it
- May seek professional advice to get an objective assessment
- Motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong resistance and defensive behaviors
- Many Contemplators have indefinite plans to take action in the next six months

PREPARATION

- Takes person from decisions made in Contemplation stage to the specific steps to be taken to solve the problem in the Action stage
- Increasing confidence in the decision to change
- Performs certain tasks that make up the first steps on the road to Action
- Most people planning to take action within the very next month
- Making final adjustments before they begin to change their behavior.

ACTION

- Specific actions intended to bring about change
- Overt modification of behavior and surroundings
- Most busy stage of change requiring the greatest commitment of time and energy
- Care not to equate action with actual change, or activity with action
- Support and encouragement still very important to prevent drop out and regression in readiness to change.

MAINTENANCE

- Sustain the changes accomplished by previous action and prevent relapse
- Requires different set of skills than were needed to initiate change
- Consolidation of gains attained
- Not a static stage and lasts as little as six months or up to a lifetime
- Learn alternative coping and problem-solving strategies
- Replace problem behaviors with new, healthy life-style
- Work through emotional triggers of relapse.

RELAPSE AND RECYCLING

- Likely, but not inevitable setbacks
- Avoid becoming stuck, discouraged, or demoralized
- Learn from relapse before committing to a new cycle of action
- Comprehensive, multidimensional assessment to explore all reasons for relapse.

TERMINATION

- This stage is the ultimate goal for all changers
- Person exits the cycle of change, without fear of relapse
- Debate over whether certain problems can be terminated or merely kept in remission through maintenance strategies.

Stages of Change and Therapists' Tasks

CLIENT STAGE	THERAPIST' S MOTIVATIONAL TASKS
Precontemplation	Raise doubt – increase the client' s perception of risk and problems with current behavior
Contemplation	Tip the balance – evoke reasons to change, risks of not changing: strengthen the client' s self-efficacy for change of current behavior
Preparation	Help the client to determine the best course of action to take in seeking change
Action	Help the client to takes steps toward change
Maintenance	Help the client identify and use strategies to prevent relapse
Relapse	Help the client renew the process of contemplation, preparation and action, without becoming stuck or demoralized because of relapse

ASAM Criteria, Dimension 5: Relapse/Continued Use/Continued Problem Potential

Sample Questions

- How aware is the patient of relapse triggers, ways to cope with cravings and skills to control impulses to use?
- What is the patient's ability to remain abstinent or psychiatrically stable based on history?
- What is the patient's level of current craving and how successfully can they resist using?

ASAM Criteria, Dimension 5: Relapse/Continued Use/Continued Problem Potential (cont.)

- If on psychiatric medications, is the patient compliant?
- If the patient had another chronic disorder (e.g., diabetes), what is the history of compliance with treatment for that disorder?
- Is the patient in immediate danger of continued severe distress and drinking/drugging or other high risk behavior due to co-occurring mental health problems?

ASAM Criteria, Dimension 5: Relapse/Continued Use/Continued Problem Potential (cont.)

- Does the patient have any recognition and skills to cope with addiction and/or mental health problems and prevent relapse or continued use/continued problems?
- What severity of problems and further distress will potentially continue or reappear, if the patient is not successfully engaged into treatment at this time?

Description of a Relapse

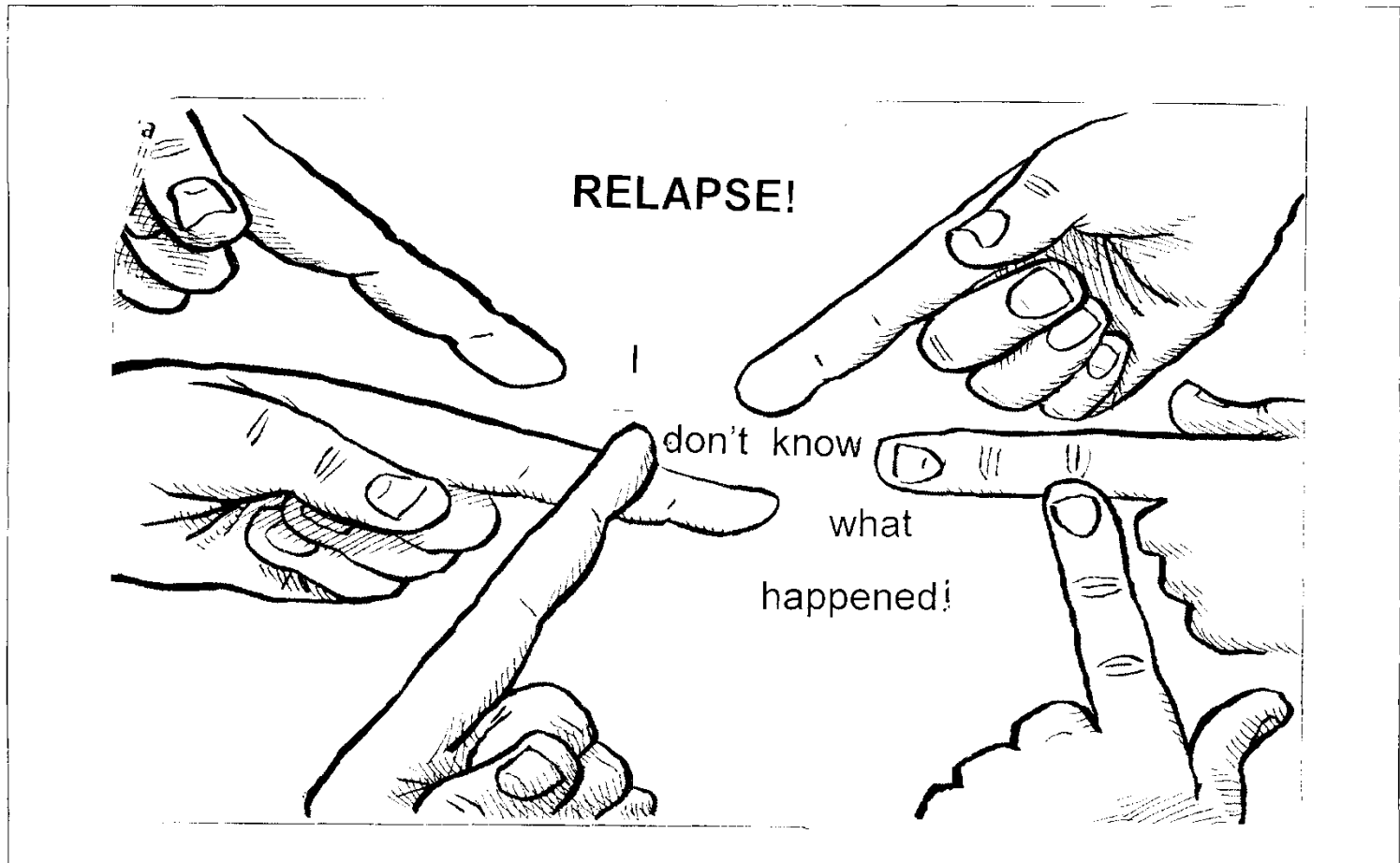
- A return to the use of psychoactive substances after a period of at least _____(?) months of abstinence/recovery,
- in an individual who has completed a course of inpatient or outpatient treatment or has had extensive recovery group experience,
- as a result of which that patient/client has made and internalized certain changes in functioning,
- which had allowed the patient to cope without resorting to the use of psychoactive substances in the interim period

Notes to Relapse

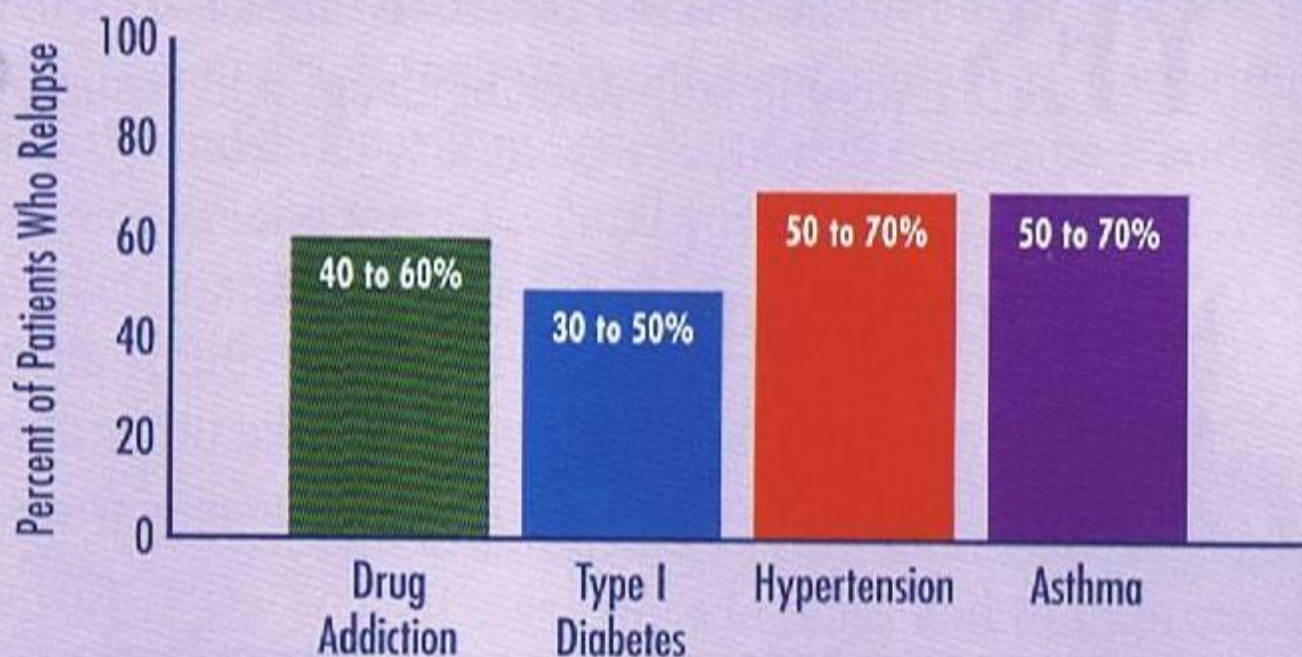
- It is assumed that the relapse process begins long before that actual substance use
- RELAPSE implies that the patient acquired and internalized certain coping skills and strategies and then something happened which brought about a return to the active addiction
- CONTINUED USE is just that (*“You can’t fall off the wagon if you never got on it!”*)

In the New ASAM Criteria

- The term “relapse” remains unchanged
- **BUT** attention is paid to the facts that:
 - The term is not used in medicine for chronic diseases, instead using “exacerbation” or “return of symptoms”
 - The term is sometimes used judgmentally with a conscious or unconscious blaming of the patient



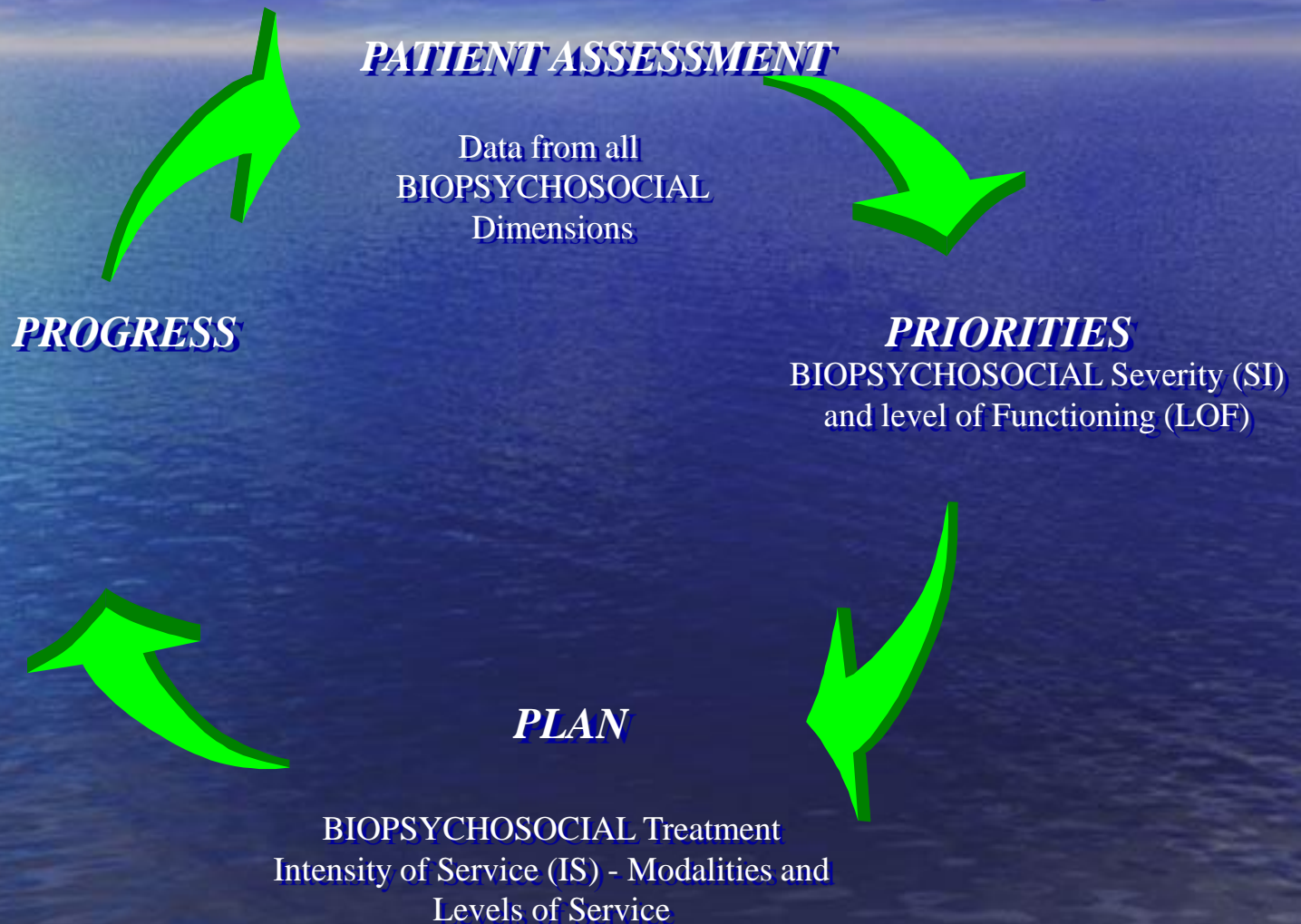
COMPARISON OF RELAPSE RATES BETWEEN DRUG ADDICTION AND OTHER CHRONIC ILLNESSES



Relapse rates for drug-addicted patients are compared with those suffering from diabetes, hypertension, and asthma. Relapse is common and similar across these illnesses (as is adherence to medication). Thus, drug addiction should be treated like any other chronic illness, with relapse serving as a trigger for renewed intervention.

Source: McLellan et al., *JAMA* 284:1689–1695. 2000.

Using the Continuous Assessment Model for Assessment of Relapse





For some Patients/Clients
the issue is

Habilitation

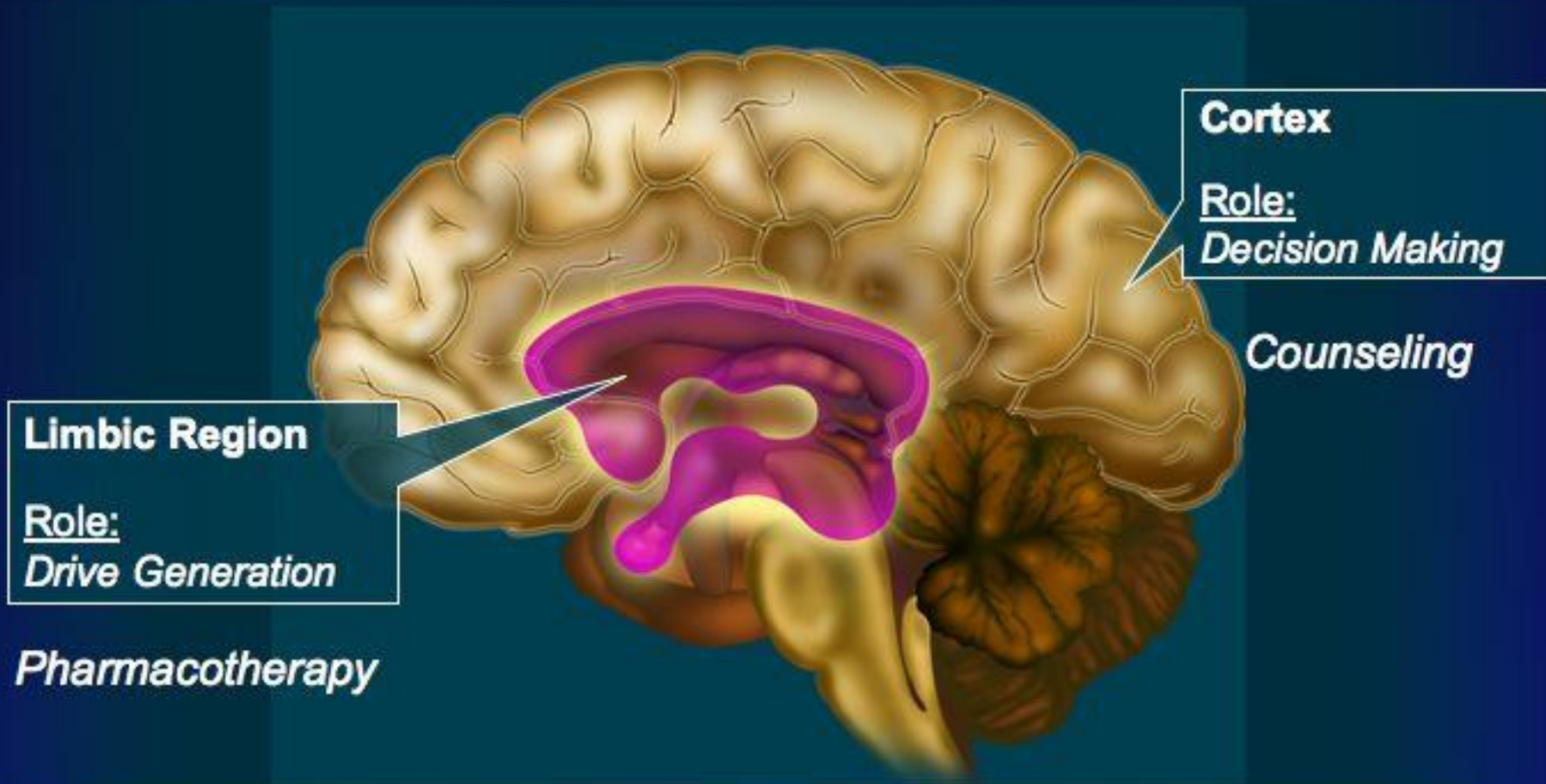
rather than

Rehabilitation

*Level of Care Placement after relapse
should be based on an assessment of
history and “**here & now**” and
NOT*

*on the assumption that if a patient
relapsed after having been treated,
then the previous level of care was not
intense enough!*

Comprehensive Alcohol Dependence Treatment



Why Psychosocial Treatments Alone Are Limited in Effectiveness

**For alcohol dependence,
consideration should
always be given to
anti-addiction medications
along with psychosocial treatment**


- Disulfiram (“Antabuse”)
- Acamprosate (“Campral”)
- Naltrexone (“Revia” & “Depade”)
- Sustained release injectable naltrexone (“Vivitrol”)

**For opioid dependence,
consideration should
be given to
anti-addiction medications
along with psychosocial treatment**

- Methadone
- Suboxone (buprenorphine + naloxone)
- Subutex (buprenorphine)
- Sustained release injectable naltrexone (“Vivitrol”)

Implications of Language

- Pharmacotherapy is often called “Medication Assisted Treatment” or MAT
- When someone with the chronic disease of diabetes uses insulin, we don’t call it Medication Assisted Treatment
- When someone with the chronic disease of hypertension uses an antihypertensive, we don’t call it Medication Assisted Treatment
- For some, MAT equals Methadone or Buprenorphine Maintenance (agonists)
- The belief that if you are on an agonist, “you are still addicted” is incorrect . . . You remain physiologically dependent!

The background of the slide is a photograph of a sunset or sunrise over a body of water. The sky is a deep blue with wispy white clouds. A bright, multi-colored rainbow is visible on the left side of the image, extending from the horizon towards the top left. The water in the foreground is dark blue with gentle ripples.

**Pharmacotherapy
should be considered
a treatment tool
as others
like group therapy or CBT**

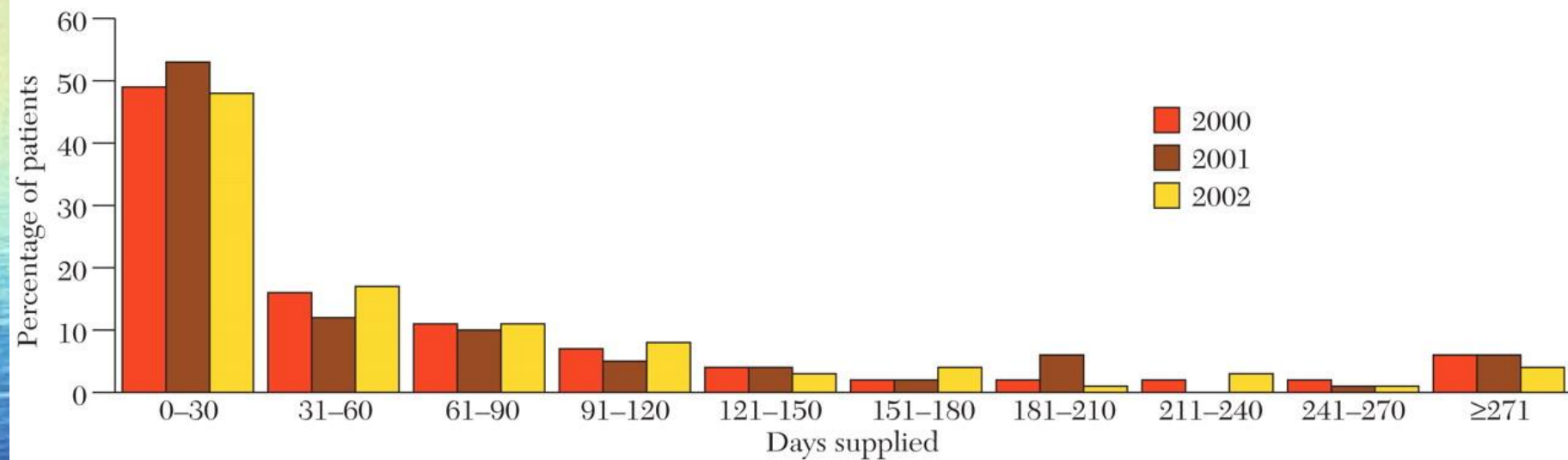


The greatest problem
with pharmacotherapy
is the lack of compliance!

Pharmacy Claims for Oral Naltrexone

Figure 1

Trends in the total number of days that naltrexone was supplied among members of a large mid-Atlantic health insurer



Pharmacy claims for NTX-PO in a plan with 1.5 million insureds for 3 years (2000-2002)

Half of patients never refilled – despite Insurance coverage



Some Research Results

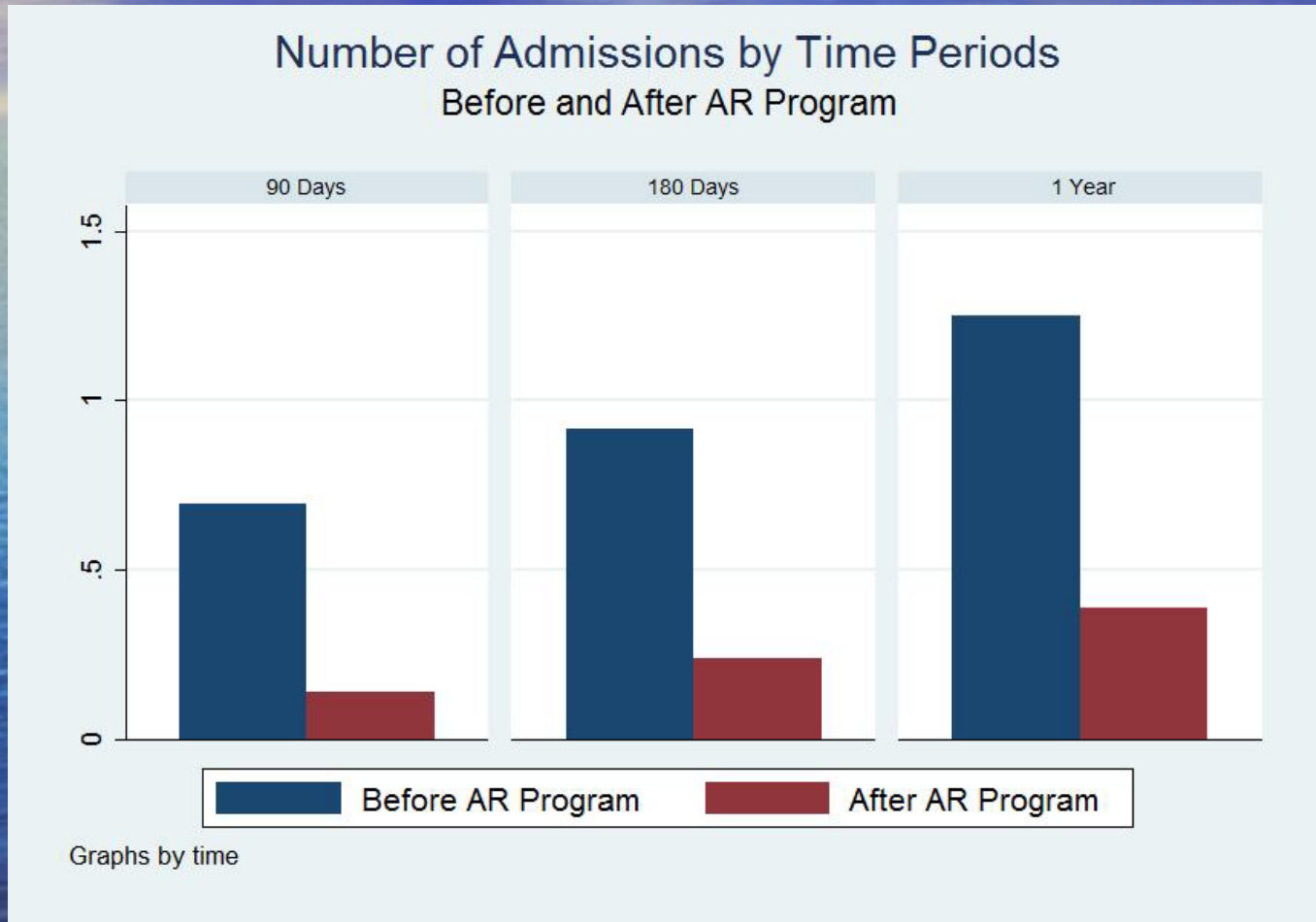
VIVITROL – Significantly Reduces Drinking Days^{1,2}



Results are from a post hoc subgroup analysis of a 6-month multicenter, double-blind, placebo-controlled clinical trial of alcohol dependents who were abstinent for 4 or more days prior to treatment initiation.

Results 2006-2008

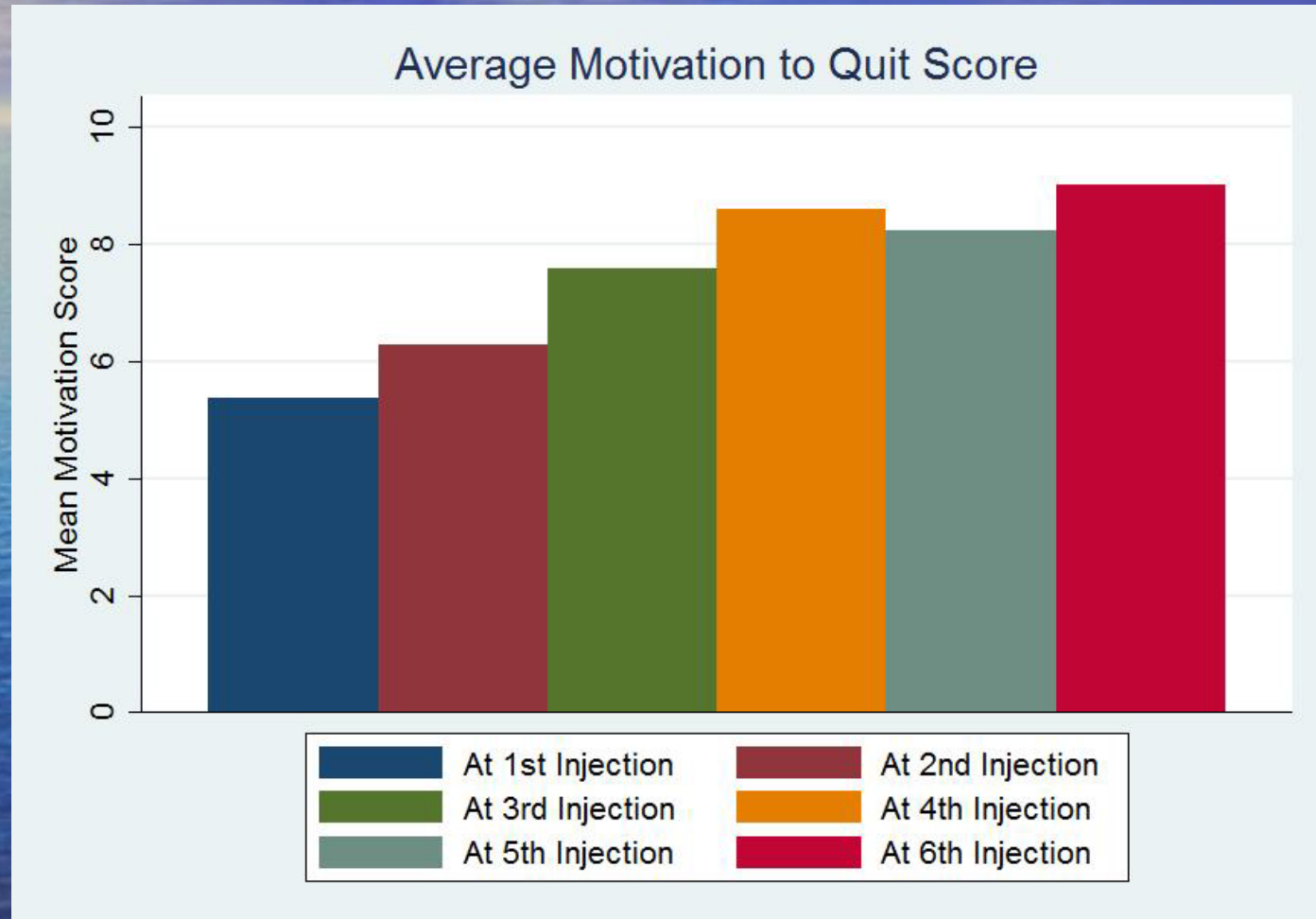
Reduced Average Number of Admissions



Florida Advancing Recovery/RWJ Foundation– Demonstration Project
N=29 patients; non-randomized; no comparison group

Results 2006-2008

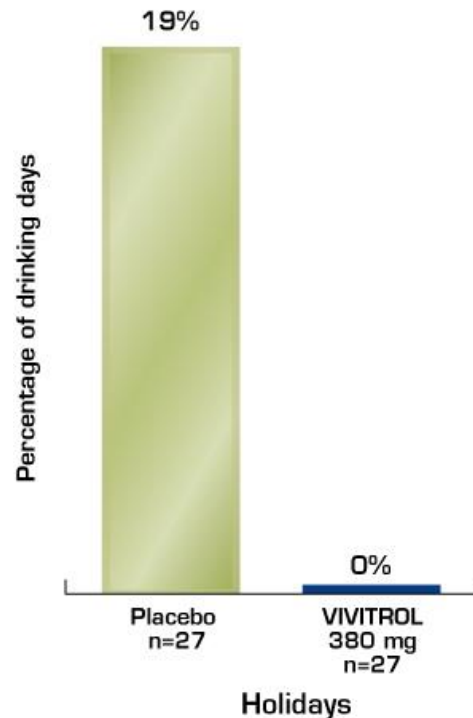
Motivation To Quit by Injection



Florida Advancing Recovery/RWJ Foundation– Demonstration Project
N=29 patients; non-randomized; no comparison group

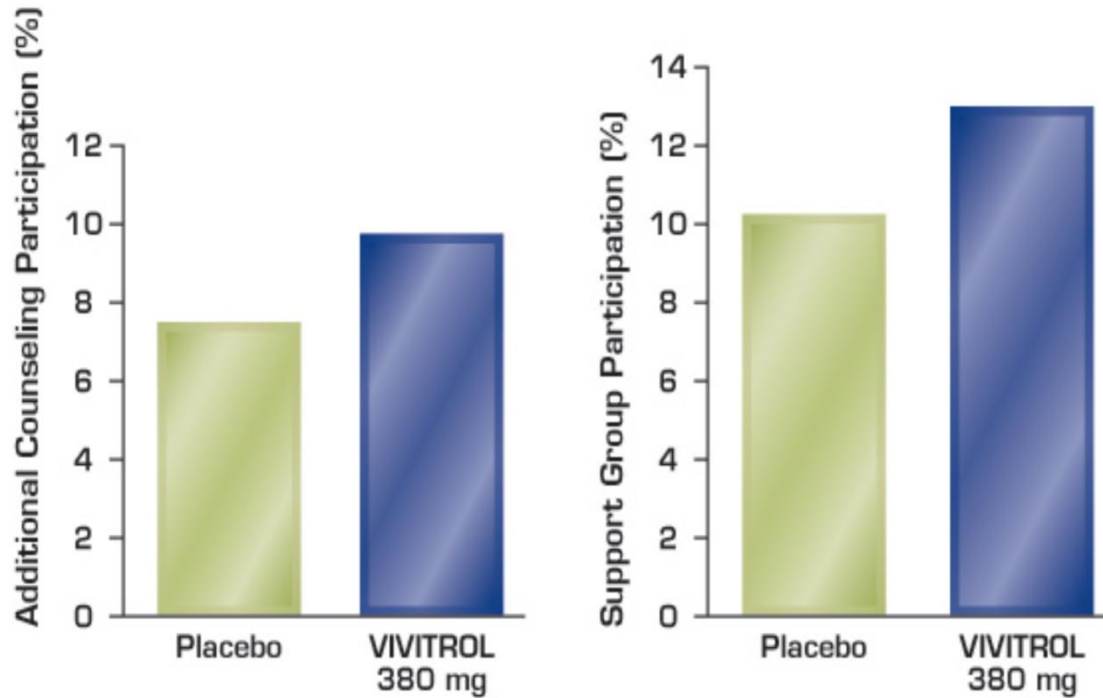
VIVITROL Reduced Holiday Drinking

Among patients who were abstinent for 4 or more days prior to treatment initiation



Similar findings were observed among patients who were abstinent 7 days prior to treatment initiation (n=53).

Impact on Participation in Counseling and Mutual Support Groups^{1,2}



1. Garbutt JC, et al. *JAMA*. 2005;293(13):1617-1625.

2. Gromov et al. AMERSA, 2008.

Northeast Recovery Division (CRC)

Vivitrol Client Outcomes

Includes clients admitted and discharged between 1/1/11 through 9/30/11 at White Deer Run - Allenwood, Cove Forge, Bowling Green at Brandywine, Wilmington Treatment Center and Life Center of Galax

	Opiate Clients Enrolled	Opiate Clients Denied	All Other Opiate Clients	Variance (Denied)	Variance (All Other)
No. of Clients:	358	460	8,053	-	-
Average Length of Stay:	23.11	17.96	15.94	29%	45%
% Treatment Complete:	87.3%	69.8%	66.5%	25%	31%
% AMA:	10.7%	24.6%	26.6%	57%	60%
Readmission Rate:	8.0%	13.4%	15.8%	40%	49%

Of all of the FDA approved medications for the treatment of opioid dependence, Vivitrol is the only one that does not produce or continue physiological dependence.

However, it does require initial abstinence of 7-10 days.



**If the Science Is There,
Why Isn't
It Used More
Commonly?"**

Erroneous Beliefs

- Erroneous beliefs that:
 - ✓ Vivitrol is meant to replace psychosocial treatments
 - ✓ Vivitrol is incompatible with AA/NA
 - ✓ Vivitrol is psychoactive or addictive

Innovations don't sell themselves . . .

- **In 1601...**

Capt. James Lancaster evaluates the effectiveness of lemon juice to prevent scurvy. Results excellent.

- **In 1747...**

Dr. James Lind carries out a second study. Results excellent.

- **In 1796 ...**

British Navy finally adopts use of lemon juice to prevent scurvy.

**H. Westley Clark,
M.D., J.D., M.P.H., CAS, FASAM
Director, Center for Substance Abuse
Treatment (CSAT)**

At the opening plenary session of the 2011 Cape Cod Symposium on Addictive Disorders (1,100 attendees), Dr. Clark said the following:

“Failing to offer and use Medication Assisted Treatment, particularly Vivitrol, is tantamount to malpractice!”

The Veteran's Administration

- The VA has determined that the use of pharmacotherapy in the treatment of addictions:

**IS THE
STANDARD OF CARE!**

United Nations

March, 2013

“A particular form of ill-treatment and possibly *torture* of drug users is the denial of opiate substitution treatment,” the report says, adding this is considered a *human rights violation when it occurs in jails and prisons*

There Is No Magic Bullet!

All of the oral anti-craving medications and Vivitrol work best in conjunction with psychosocial treatment and/or recovery support services.

Srisurapanont M, Jarusuraisin N (2005). Opioid antagonists for alcohol dependence. Cochrane Database of Systematic Reviews .

***Oral Naltrexone and Vivitrol Are
SUPPLEMENTS, Not
REPLACEMENTS!***

IF I really believe that *Addiction is a chronic, relapsing brain disease,*

THEN I will treat it as a chronic disease

which means consideration of the use of medications as would occur with other chronic diseases such as hypertension and diabetes.

Be Aware

**Conviction
is a greater enemy
of truth
than are lies**

Neitsche

ASAM Criteria, Dimension 6: Recovery Environment

- **Sample Questions**

- Are there any dangerous family, significant others, living or school working situations threatening treatment engagement and success?
- Does the patient have supportive friendship, financial or educational/vocational resources to improve the likelihood of successful treatment?

ASAM Criteria, Dimension 6: Recovery Environment (Cont.)

- **Sample Questions**

- Are there barriers to access to treatment such as transportation or child care responsibilities?
- Are there legal, vocational, social service agency or criminal justice mandates that may enhance motivation for engagement into treatment?
- Is the patient able to see value in recovery?



HOMELESSNESS
alone is
NOT
sufficient reason
for a Level 3 Placement!



I admire people

Who barely have anything but share it nevertheless

Dimension 6 Issues As or More Important Than Treatment

- Housing
- Education
- Literacy
- Employment
 - Ex-Felons
- Child Care
- Re-entry from prison
- Opportunity

The more disadvantaged and complicated the patient, the more important is **CASE MANAGEMENT**

- Co-occurring medical and psychiatric disorders
- Adolescents
- Ex-Felons
- Older Adults
- Welfare/disability clients
- Financial problems needs
- Parenting needs

**Without these needed services,
here is where we are:**



Demographic Predictors of Poor Treatment Outcome (both MH & SA)

- 1.** Under 25 years of age
- 2.** Never married or having lived as married
- 3.** Unemployed
- 4.** No high school diploma or GED

WHAT MATTERS MOST
IS HOW YOU SEE YOURSELF.



“Discharge Planning” is part of
treatment planning,
NOT a discrete activity

*(90 meetings in 90 days
is **NOT** a discharge plan!)*

What kind of discharge planning are providers doing?





Problem Determination & Prioritization

Individualized Treatment



PATIENT ASSESSMENT

Data from all
BIOPSYCHOSOCIAL
Dimensions

PRIORITIES

BIOPSYCHOSOCIAL Severity (SI)
and level of Functioning (LOF)

SERVICE PLAN

BIOPSYCHOSOCIAL Treatment
Intensity of Service (IS) - Modalities and Levels of Service

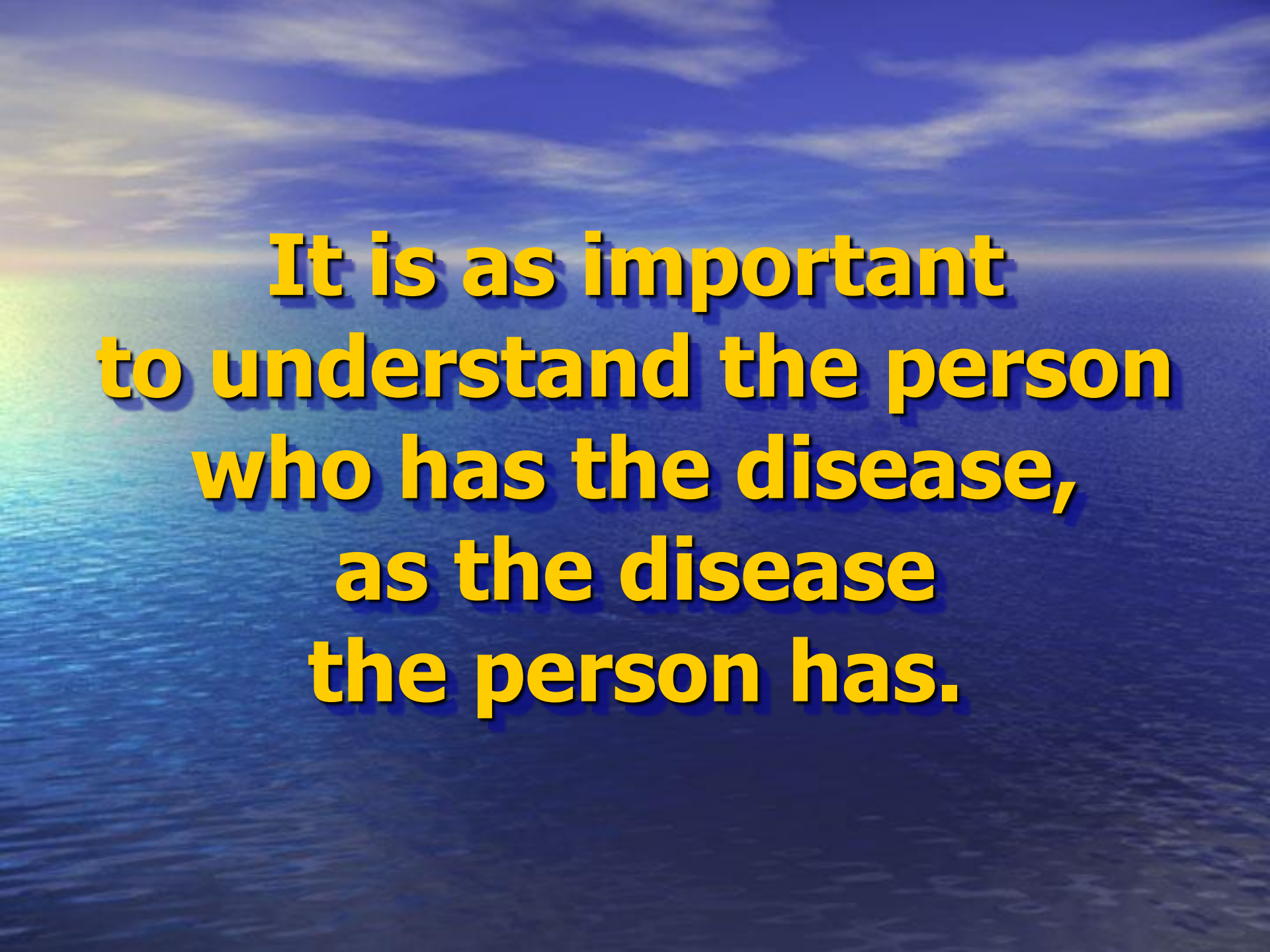
PLACEMENT

PROGRESS

Response to Treatment
BIOPSYCHOSOCIAL Severity (SI)
and Level of Functioning (LOF)

Service Plan

- A determination of needed services and interventions
- Followed by the selection of level of care where those services are available
- Not a formal treatment plan



**It is as important
to understand the person
who has the disease,
as the disease
the person has.**

Continued Service and Discharge Criteria in the ASAM PPC-2R

- The patient meets continued service criteria is he or she:
 - ✓ has not yet resolved the problems that justified admission but is working on them and making progress
 - ✓ Has resolved the problems that justified admission but new problems which can only be dealt with safely at the current level of service have surfaced

Continued Service and Discharge Criteria in the ASAM PPC-2R (cont.)

- The patient meets discharge criteria if he or she:
 - ✓ has resolved the problems that justified admission and can now be treated at a less intensive level of service
 - ✓ Is unable to resolve the problems and requires different services that can be provided at the same level of care or a different level of care
 - ✓ has resolved the problems but new problems have arisen which require different services or a different level of care (e.g., an individual in a Level III.5 becomes acutely suicidal and must be transferred to a Level IV, Dual Diagnosis Enhanced service)



CASE STUDIES

Assessment for Severity Must Be Done ***Within and Between*** Dimensions

- High severity in one dimension can increase severity in one or more other dimensions
- Low severity in one dimension can decrease severity in one or more other dimensions

The Three H's of Assessment

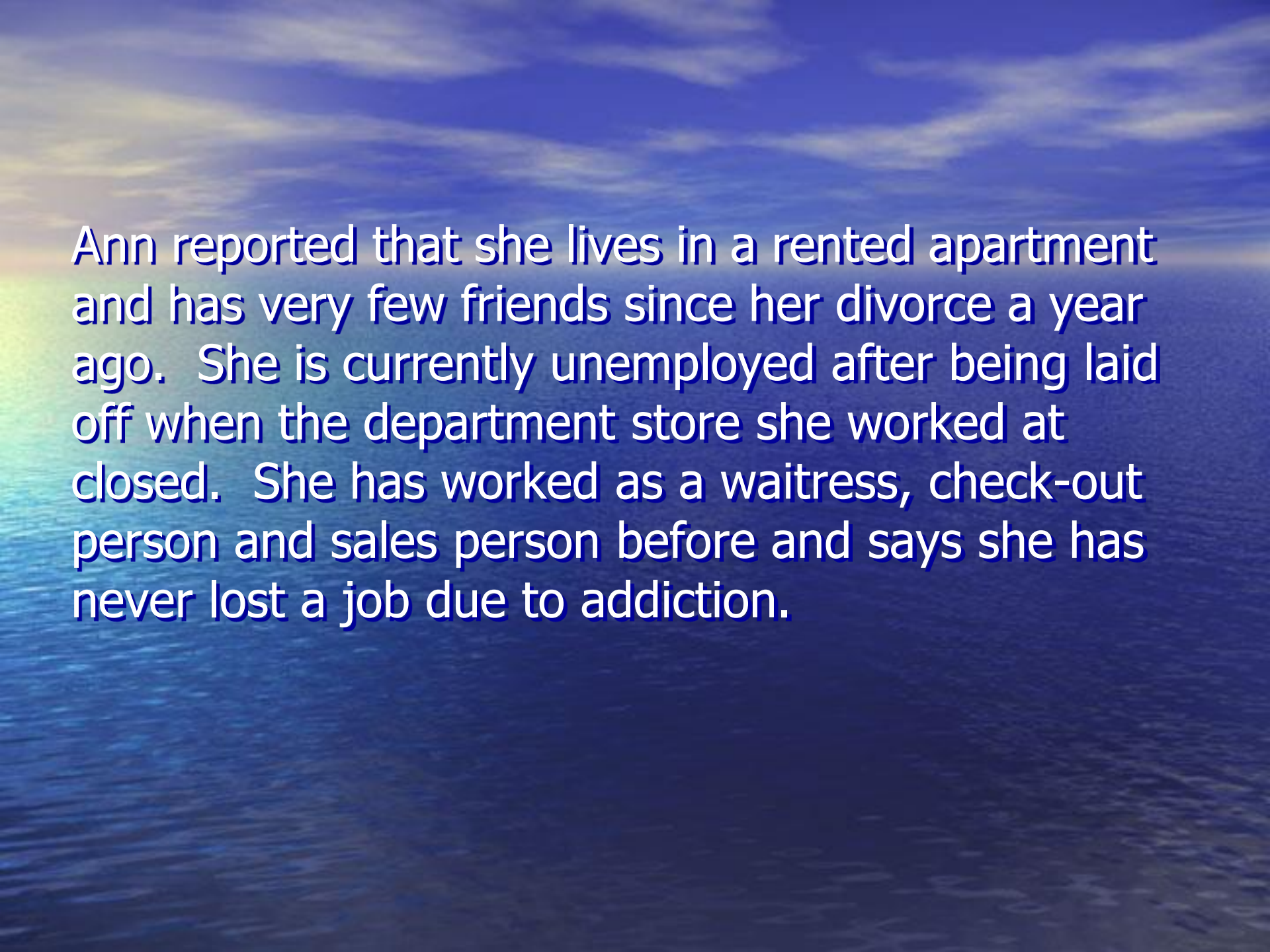
- **H**istory
- **H**ere and Now
- **H**ow uncomfortable are you?

"Ann"

DSM 5 Diagnoses: Alcohol Use Disorder, Severe; Marijuana Use Disorder, Mild; Major Depressive Disorder in Sustained Remission

Ann, a 32 year old white, divorced female, came in for assessment for the first time ever. She has been abstinent for 48 hours from alcohol and reports that she has remained so for up to 72 hours during the past three months. When she has done this she states she has experienced sweats, internal tremors and nausea, but has never hallucinated, experienced D.T.'s or seizures.

She states she is in good health except for alcoholic hepatitis for which she was just released from the hospital one week ago. Her doctor referred her for assessment. She smokes up to 2 joints a day, but stopped yesterday. In addition to the above, Ann describes two past suicide attempts using sleeping pills, but the most recent attempt was three years ago and she sees a psychiatrist once a month for review of her medication. She takes Prozac for the depression and reports taking her medication as prescribed.



Ann reported that she lives in a rented apartment and has very few friends since her divorce a year ago. She is currently unemployed after being laid off when the department store she worked at closed. She has worked as a waitress, check-out person and sales person before and says she has never lost a job due to addiction.

Ann appears slightly anxious, but is not flushed. She speaks calmly and is cooperative. Ann shows awareness of her consequences from chemical use, but tends to minimize it and blame others including her ex-husband who left her without warning. She doesn't know much about alcoholism/chemical dependency, but wants to learn more. She has one son, age 11, from a previous marriage, who doesn't see any problems with her drinking and doesn't know about her marijuana use.

ASAM DIMENSION SEVERITY WORKSHEET

ASAM Dimension	Risk Rating				
	(0) No Problem	(1) Mild	(2) Moderate	(3) Significant	(4) Severe
Dimension 1: Acute Intoxication and /or Withdrawal Potential					
Dimension 2: Biomedical Conditions & Complications					
Dimension 3: Emotional, Behavioral, Cognitive Conditions & Complications					
Dimension 4: Readiness to Change					
Dimension 5: Relapse, Continued Use, Continued Problem Potential					
Dimension 6: Recovery Environment					

Ann – Four Months Later

At a follow-up visit four months later, Ann reports that she has been abstinent from alcohol for almost four months. She has transitioned well to less intensive levels of outpatient care, has been discharged from a Level 1 program, and is attending self-help group meetings two to three times a week. She has not used marijuana for the past two weeks. Her liver function test results are within normal limits.

Ann – Four Months Later

However, Ann discloses that her sister, from whom she had been estranged, died recently, before they could reestablish their relationship. She feels guilty that she was unable to bring about a rapprochement. She also has become involved in a relationship that she describes as being “madly in love.” The man in question moved in with her, but after coming home from an AA meeting she discovered him in bed with a friend. She has fallen into a deep depression even though she continues to use her anti-depressant medication.

Ann – Four Months Later

Ann reports that, for the first time in three years, she occasionally thinks about suicide, although she says she does not have an active plan. She reports that she is barely able to care for her son. She started a new job as a salesperson, but is still in her initial probationary period and has called in sick for the past two days.

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Second Time Around Sam

Referred for DWI Assessment

A 43 year old, black male, heating and air conditioning technician with 19 years of service with the company was referred to EAP after being cited for DUI. He has had a recent (last two months) pattern of tardiness and coworkers have noticed the smell of alcohol on him on several occasions. BAC for the DWI was 0.24gms/%.

The patient reports that he has been in a 28 day inpatient alcoholism rehabilitation center seven years ago after which he abstained from alcohol for 1 and 1/2 years. He claims current daily usage is 5 - 7 beers on weekdays and up to 12 beers/day on the weekends. He has recently been diagnosed with pancreatitis. He does not admit to being alcoholic but is willing to enter treatment to keep his job.

He lives with his two daughters, ages 17 and 15. He has been divorced for four years, has custody of the children and admits that his alcohol use was a contributor to the divorce. He does not currently have a significant other nor does he date much. Stressors include a new job, a custody suite initiated by his ex-spouse and an upcoming 6 month redeployment to another job site 250 miles away. He admits to feeling stressed, somewhat depressed which creates cravings to drink and he has experienced fleeting suicidal ideation.

On evaluation he was found to be anxious and states his use of alcohol is to alleviate depression and loneliness. He had no periods of abstinence from alcohol exceeding two days in the past five years. When he does stop drinking, he experiences moderate to severe shakes and describes passing out, which upon further assessment has likely been a withdrawal seizure. He has not attempted to stop drinking and describes his social support system as "weak."

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Sam – Three Weeks into Treatment

During Sam's third week in treatment, there was an exacerbation of his depressive symptoms. He began to talk about being overwhelmed by all the problems that he had, his fears of losing his daughters and expressed serious doubts about whether he could recover as he did before. His suicidal ideation has increased and while he still has no plan, he claims to be thinking about suicide on a daily basis.

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Sandy

- This 26 year old, white female contacted the clinic herself asking for help. An assessment by the counselor revealed the following:
- She has been snorting cocaine off and on for about four years, and for the last year, 3-4 times a week, 1-2 lines at a time.
- She drinks 2-3 drinks at a time, 2-3 times a week, with occasional drinking to intoxication on the weekends.
- She smokes marijuana, 1-2 joints at a time, 1-2 times a week.

Sandy

- She claims to want help to stop using all the psychoactive substances, but especially the cocaine, because while she likes some of the psychoactive effects, she doesn't like being "out of it," even minimally. She had a DUI about two years ago (she does not know what her BAC was). Recently Sandy found herself wandering in a park near her home and does not remember how she got there. This has frightened her.

Sandy

- She has no medical problems of significance that would interfere with treatment. During the assessment, Sandy appeared somewhat anxious and mildly depressed, most of which may be accounted for by the assessment situation.
- Sandy and her husband have been separated twice, once for three weeks and once for one month in the last two years after she moved out. She has been able to stay off all drugs and alcohol during the time they were separated and for about one month each time after she returned from the marital separations. She states that her husband supports her in her attempts to get help for her substance use.

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treatment if that is the only way he can stay out of jail

Fred lives with his wife and two children. Nothing is known at this time about this relationship or his wife's pattern of psychoactive substance use, if any. A referral to the plant physician shows a BAC of 0.0gms%. There are no signs of withdrawal in evidence. Fred is also diabetic but controlled with insulin and diet. A current blood sugar assessment is in the normal range. There are no other medical problems in evidence.

On evaluation by the counselor, the client was found to be quite anxious and he explained some of his absenteeism from his job by describing himself as being 🙌 too blue🔪 to come to work.

In response to questions about his cocaine use, the client claims he only used this one time (leading to the positive drug screen). He has had no periods of abstinence from alcohol exceeding 48 hours over the last 15 years but states that he has never tried to stop drinking. He refuses to have his wife contacted.

Positive Toxicology Screen for Cocaine Metabolite

A 38 year old male probationer is referred for a chemical dependency assessment because of positive results for cocaine on a random drug screen. Initial assessment reveals a pattern of daily drinking. The employee's job supervisor states that there has been a history of absenteeism beyond what is usual (he has used all of his earned time at work) and a pattern of borrowing money from co-workers.

The probationer denies any problem with cocaine or alcohol but does not want to be violated (his probation officer will permit one treatment after a positive drug screen in lieu of violation of probation). He says that he is willing to enter treatment if that is the only way he can stay out of jail.

Positive Toxicology Screen for Cocaine Metabolite

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Newly Divorced Becky

Becky is a 46-year old divorced white female who was in an 18 years marriage characterized by emotional abuse, infidelities by both her and her husband and regular and sometimes heavy marijuana and alcohol use. Since the divorce her drinking and marijuana use have increased when using, but she using only sporadically, no more than twice a month. About two years ago she began seeing a counselor and at her suggestion, she began attending Al-Anon. Her counselor retired from practice and Becky never followed up on the referral that she gave her.

Newly Divorced Becky (cont.)

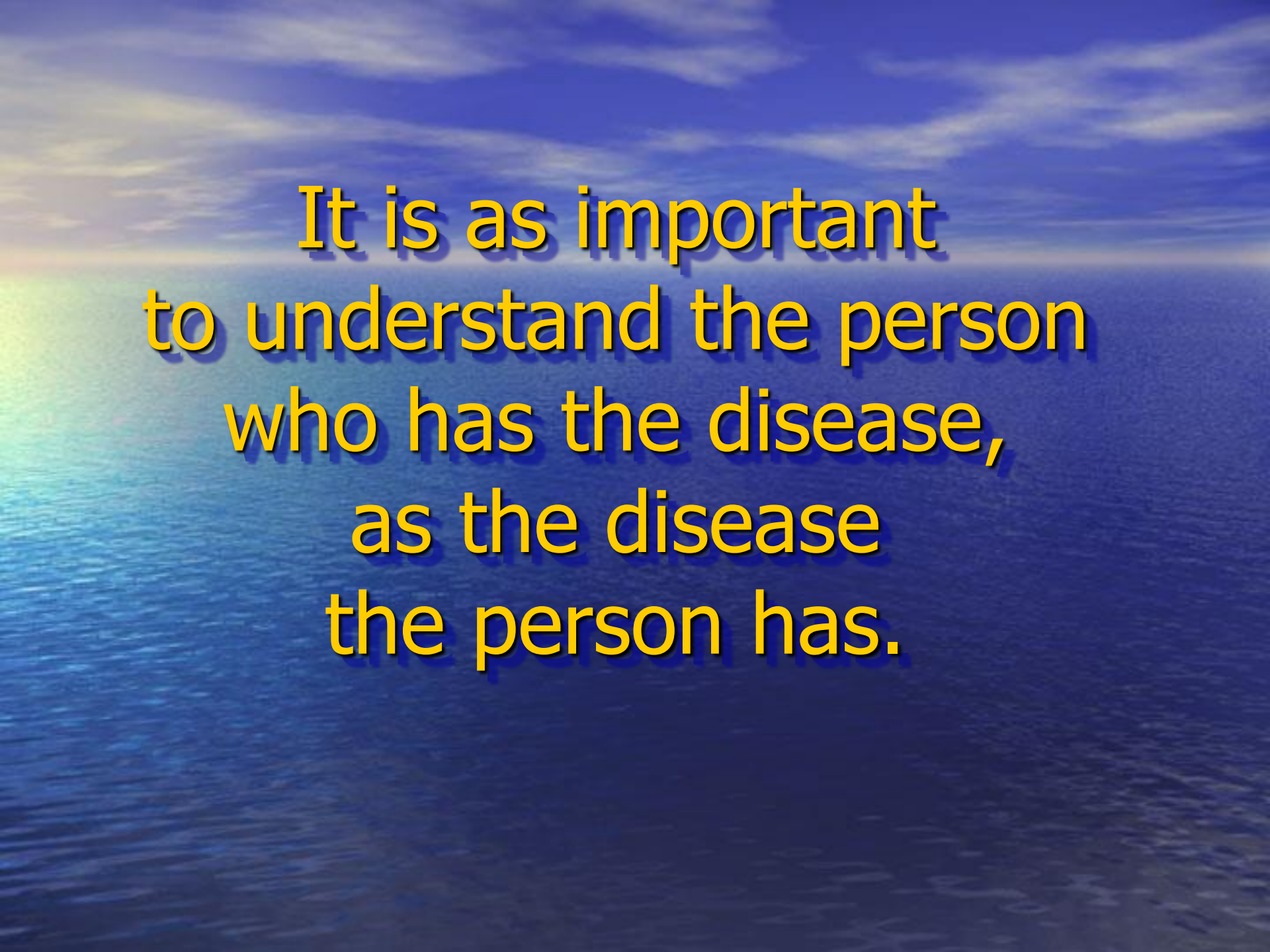
She is the child of an alcoholic father who was seductive but not openly sexual with her as she was growing up and whom she alternately idolized and feared. She is the younger of two female children and her older sister is a teetotaler. Her father committed suicide during the first year of her marriage. Her mother, 67 years old, lives alone and is still in denial about Becky's father's alcoholism. She describes herself as codependent and uses as an example how long she stayed with her husband who was the child in their parent-child relationship.

Newly Divorced Becky (cont.)

A year ago she began attending AA (also a suggestion that her counselor had made to her) and she enjoys it. She attends weekly. She now drinks about once a month without apparent problem. She no longer smokes pot. She does feel hypocritical attending AA and still drinking but she neither wants to stop drinking nor discontinue her AA attendance because she has a few women friends there. They do not know about current her drinking. She sought out a counselor this time because of her dissatisfaction with her life. She does not believe that she has a drinking problem. She is not sure what she wants, other than what she has.

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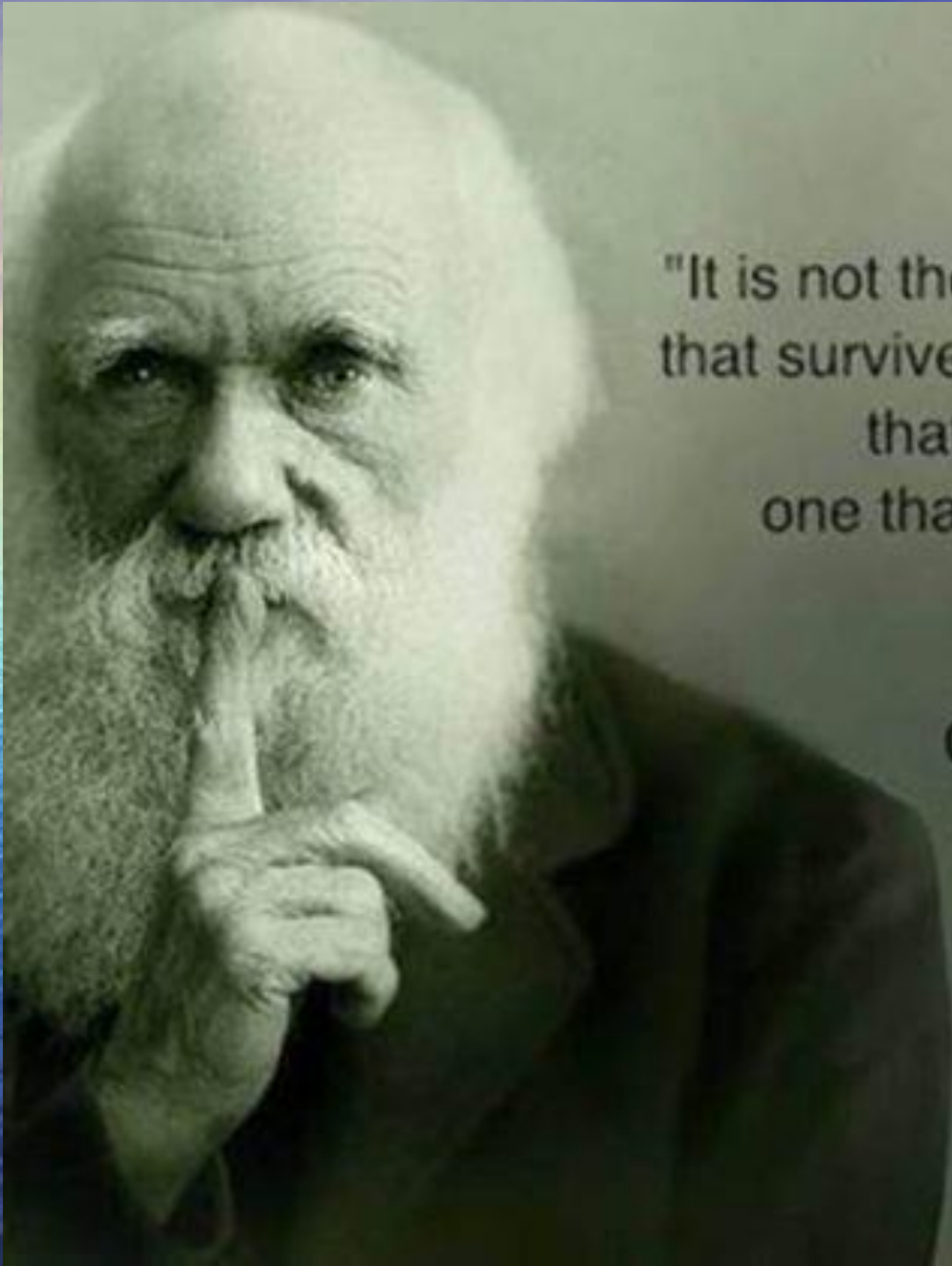


If patients
can't get
better the way
we provide
treatment,
maybe we should
provide
treatment
the way
they can

www.Jokeworm.com



*"Some days you just have to look at
the world in a different way!"*



"It is not the strongest of the species
that survives, nor the most intelligent
that survives. It is the
one that is most adaptable to
change".

Charles Darwin



Hey! Don't just
have a good day..
Instead have a
Fantastic, Great,
Super-Duper,
Totally Awesome,
Wonderful Day!

